REPORT

ON THE

HEALTH INSURANCE FOR INDUSTRIAL WORKERS

ADARKAR

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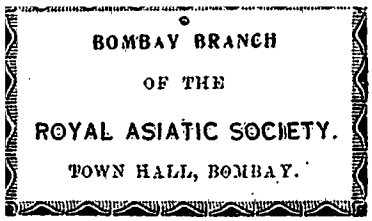

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REPORT

on

Health Insurance for Industrial Workers

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By Professor B. P. ADARKAR, M.A. Cantab.,
Officer on Special Duty, Labour Department,
Government of India

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1944

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To

The Hon'ble Mr. H. C. PRIOR, C.S.I., C.I.E., I.C.S.,
Secretary to the Government of India,
Department of Labour, New Delhi.

SIR,

I have the honour to submit the enclosed Report on a Scheme of Health Insurance for Industrial Workers to prepare which I was appointed as a Special Officer in March 1943. In framing the Scheme, I have had the benefit of consultations with the Actuarial Advisory Committee, the Panel of Advisers representing employers and workers, the Industrial Health Sub-Committee of the Health Survey Committee, officials of the Labour Department and the Education, Health and Lands Department of the Government of India, Labour Commissioners and other officials of some of the Provincial and State Governments, as also a number of non-officials, including employers, labour leaders and medical practitioners. I wish to make it clear, however, that I alone am responsible for the views expressed and recommendations made by me in this Report and that they are not binding upon the Government of India or on any of the other parties concerned with health insurance. The value of the views and recommendations, if any, lies in the fact that they have been based upon an impartial appraisal of the divergent factors involved and upon such study as I could make of the various aspects of the subject.

I have the honour to be,
SIR,
Your most obedient servant,
B. P. ADARKAR.

SIMLA,
15th August 1944.

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PRELIMINARY

1. I assumed charge of my duties as Officer on Special Duty, Sickness Insurance, on the 16th March 1943. Although no special terms of reference as such were indicated to me, the decisions arrived at at the various Conferences of Labour Ministers in connection with the subject, and communications (*vide* Appendix I) of the Labour Department of the Government of India to Provincial Governments and to leading Associations of employers and workers provided the necessary background for developing the scheme. As may be seen, however I have not allowed myself to be cramped by the measures suggested earlier if they appeared to be contrary to the basic ideals of social insurance and the true interests of labour. It will appear from the proceedings of the Ministerial Conferences and the above-mentioned communications that the following assumptions could be made :—

(i) That the Scheme would be a compulsory one.

(ii) That it would be based mainly upon contributions by employers and workers, and that the Provincial Governments and the Government of India would come into the picture as providers of a Guarantee, i.e., of loan facilities in the event of the scheme becoming financially unstable. (But see Chapter IX, Section A.)

(iii) That it would apply in the first instance to the three major groups of industries, viz., all " textiles ", all " engineering " and all " minerals and metals ", as classified under the Factories Act Statistics. (It was originally the decision that only cotton textiles, jute textiles and heavy engineering should be covered. This decision was subsequently revised. A reference was made by me to the Labour Department stating that it would be difficult to define precisely and legally the terms, " heavy " engineering, " cotton " textiles, etc., in such a manner as to leave no loopholes for evasion or litigation. On this basis the Labour Department addressed a letter to all Provincial Governments and after receiving their replies informed me that the scheme would apply to the above three groups of industries only, in the first instance.)

(iv) That the Indian States would be covered for enquiry only, at this stage and that they would be free to join an all-India scheme later, if they so desired.

2. In pursuance of the decision of the Third Conference of Labour Ministers, a Panel of Advisers was appointed to advise me on all matters relevant to the framing of the Scheme. The Panel consisted of representatives of the four leading organisations of employers and workers : Messrs. S. C. Joshi and S. S. Mirajkar (on behalf of the All India Trade Union Congress), Messrs. V. M. Tarkunde and George Lobo (on behalf of the Indian Federation of Labour); Messrs. G. M. Garrie, A. H. Bishop and J. C. Lancashire (on behalf of the Employers' Federation of India) and Sir Shri Ram and Mr. Kasturbhai Lalbhai (on behalf of the All India Organisation of Industrial Employers).

3. I proceeded to my headquarters, Bombay, immediately after taking charge in Delhi, and on arrival got into touch with such of the Advisers on my Panel as were then available in Bombay. Then I proceeded on a tour of important industrial centres in North India with a view to personal contact with officials, employers, workers and others. Leaving Bombay on the 6th April 1943, I visited Ahmedabad, Delhi, Calcutta, Tatanagar, Nagpur and Cawnpore and returned to Bombay on the 1st May. Between the 1st May and the 16th May, I met representatives of employers and workers, as also some of the officials who

had gathered in Bombay for a meeting of the Standing Labour Committee of the Government of India. On the 17th May, I commenced my South Indian tour and visited Madras, Coimbatore, Madura and Bangalore. I wished to visit some of the other centres in the South but owing to heavy rains, train traffic was dislocated throughout the Madras Province and hence I had to return to Bombay on the 27th May. Towards the middle of June, I visited Simla to have discussions with the then Superintendent of Insurance, Mr. P. V. Krishnamurthy, and for this purpose, while in Simla, I prepared a Nuclear Portion of the Draft Scheme. This Nuclear portion was also discussed with the Labour Department and formed the central part of the Draft Scheme (Interim) which was prepared later. After this, I visited Ahmedabad on the 16th and 17th July and met representatives of the Ahmedabad Millowners' Association and the Textile Labour Association, Ahmedabad. Towards the end of August, I paid a visit to Bangalore where the Labour Commissioner kindly arranged meetings with representatives of employers and labourers. Next month, I proceeded to Baroda for similar meetings. By the end of October, I had to visit Calcutta a second time for consultations with Panel Advisers and also with representatives of the Indian Medical Association. On return, I met the D. G., I. M. S., and other medical authorities in New Delhi on the 29th October.

4. In the meanwhile, with a view to obtaining the views of various parties including officials, Provincial and State Governments, actuaries, medical associations, and employers' and workers' associations and collecting statistical and factual data, I issued general and special Questionnaires (six in number) on different dates. A large mass of useful information and opinion was thus available. The questionnaires have been reproduced in full in Appendix IV. Lists of names of officials, employers' and workers' associations, actuaries, medical associations and practitioners, etc., who kindly replied to the questionnaires, are given in Appendix V. Statistical and other relevant factual information bearing upon the incidence of sickness among industrial workers has been collated and reproduced in Appendix VI.

5. After receiving replies to questionnaires and having consulted the Panel Advisers in regard to the general aspects of health insurance, towards the end of August 1943, I prepared and submitted an interim Draft Scheme, outlining the main structure of health insurance and its machinery. The main purpose of this interim report was to facilitate a preliminary actuarial examination of the scheme and also to obtain the reactions of the Panel Advisers. For the actuarial examination, an Actuarial Committee was set up in October 1943, with Mr. L. S. Vaidyanathan, F.I.A. (now Superintendent of Insurance) as Chairman, and Mr. S. N. Vaidya, F.I.A. and Mr. B. K. Shah, F.I.A., as Members, with appropriate terms of reference. The Actuarial Committee were asked " to consider and advise generally from the actuarial angle on the preliminary draft scheme prepared by Professor Adarkar and subsequent alterations thereof, in the light of the views of Government.....and, in particular, on (1) assessing within reasonable limits the financial implications of the scheme and (2) the forms of cards and other statistics necessary to be collected in administering the scheme, linking-up rules and setting up reserves." In the light of discussions with the Panel Advisers and Actuaries, certain alterations were made in the interim Draft Scheme. The present Report is an amplification of the Draft Scheme as amended. The Report of the Actuarial Committee is appended to this Report.

6. In conclusion, I desire to acknowledge the assistance and encouragement I received from various quarters. My special thanks are due to the Hon'ble Dr. B. R. Ambedkar and the officials of the Labour Department for encouragement and general guidance and to officials of the Health Departments

of the Government of India and the Health Survey and Development Committee for opportunities for discussion on important medical aspects of the scheme To Advisers or the Panel, representing the four major employers' and workers' organisations, I am indebted for co-operation and advice. The Actuarial Advisory Committee and in particular, its Chairman, Mr. L. S. Vaidyanathan, the Superintendent of Insurance, and his staff, have rendered valuable assistance on the actuarial side. My thanks are also due to the actuaries who replied to the Acturial Questionnaire. Acknowledgments are due in a large measure to the Labour Commissioners in the Provinces and States and to their staffs, for having helped me in contacting employers and workers, for having given various facilities during my tour and for having supplied valuable data. The Labour Office of the Government of Bombay requires special mention for permitting me the use of its commendable library. Thanks are due to the International Labour Organisation, Delhi Branch, and its able Director, Dr. P. P. Pillai, for useful information and suggestions. Thanks are also due to the various individuals, associations of employers, workers and medical men, and to the Surgeons-General of Provinces for having placed at my disposal views and information through discussions and replies to questionnaires. Finally, I must place on record my acknowledgment of the assistance which I have received from my staff. Mr. A. N. Agarwala, Research Assistant, and his successors, Messrs. S. D. Punekar and V. Jagannatham have been extremely helpful in regard to research in problems of social insurance and collection of factual and statistical information while my Assistant, Mr. R. V. Mathai has not only managed the office routine ably but done a considerable amount of statistical work for me. My thanks are due to them and to my hard-working and efficient Stenographer, Mr. K. P. P. Pillai.

SUMMARY OF THE REPORT

Chapter I.—Introduction.

A. Health Insurance is traditionally as well as organically the most important measure of Social Insurance. It attacks the twin Giants of Want and Disease, from amongst the Five Giants mentioned by Sir William Beveridge in his monumental report (the other three Giants being Ignorance, Squalor and Idleness). In India, where all these Giants flourish unabatedly, the beginnings of social insurance date from the passing of the Workmen's Compensation Act and the various Maternity Benefit Acts ; but both these measures fall short of the true ideal of *social* insurance. Of all the occupational and social risks covered by social insurance, that of sickness undoubtedly possesses the greatest social interest. And yet, in India, unfortunately, the proposal of health insurance has had a long and somewhat chequered history.

B. The Royal Commission on Labour (1930-1) made out a strong case for health insurance in India and even proposed a tentative scheme in bare outline. Since then, this question has gathered momentum. The recent appointment of the Health Survey and Development Committee by the Government of India for preparing a nation-wide programme of health, however, adds interest to the question whether health insurance is the best method of tackling the problem of industrial health. It is clear that it is not merely a matter of providing medical treatment, but that some mechanism is necessary to secure the worker against Want during spells of sickness. The function of health insurance is stated to be threefold : Restoration, Compensation and Prevention. There is no doubt that there is a strong case for health insurance for industrial workers.

C. Three important schemes proposed respectively by the Royal Commission on Labour in 1931, the Labour Department of the Government of India in 1941-42, and the Bombay Textile Labour Enquiry Committee in 1940, may be considered in this connection. The schemes were of a very tentative character, but there are some useful features in them which deserve consideration.

D. There are difficulties, both real and imaginary, in the way of introducing a scheme like the present one in India, but it is not considered that any of them are insuperable.

E. Certain assumptions are necessary and implicit in the successful adoption of a scheme of health insurance. These are (1) the early adoption of a scheme of Unemployment Insurance and the creation of new Employment in the post-war period, through a drive for national planning and development ; (2) the establishment of a scheme of Old Age Pensions ; (3) the adoption and enforcement of certain " pre-medical " measures, such as regulation of wages, rigorous enforcement of factory laws, housing, nutrition, education in health, and improvement of environmental hygiene ; and (4) a National Health Drive. These measures are necessary to keep down the incidence of sickness to the minimum possible and to prevent the scheme from being saddled with burdens legitimately belonging to other aspects of social security.

F. Certain fundamental principles have been adopted in the framing of the present scheme. They are : (1) The scheme must be a *compulsory* one, if it is to be of any real value to the working classes ; (2) it must be a *contributory* one, as far as possible ; (3) it must be simple, clear and straightforward, from the viewpoint of those who will administer it, those who will pay for it and those who will benefit by it ; (4) it must take the existing framework of labour legislation as its formal basis, as far as possible ; (5) it must not be too ambitious in the beginning ; (6) it must be financially sound, economical in its working, and, as far as possible, actuarially balanced ; (7) it must minimise disputes and litigation and at the same time close all loopholes for malingering, collusion and commission of offences ; (8) it must be workable in the peculiar circumstances of Indian labour and industry ; (9) it must, as far as possible, be in conformity with the International Labour Conventions ; (10) it must not be allowed to be inappropriately burdened with financial responsibilities which properly belong to other measures of social security ; and (11) finally, it must be flexible, leaving sufficient scope for subsequent alterations and extensions.

Chapter II.—The Scope of the Scheme.

A. The scheme covers three major groups of industries, viz., all Textiles, all Engineering, and all Minerals and Metals. All perennial factories, excepting those " scheduled " below, will be covered.

B. There will be " Scheduled Exceptions " such as (a) employment in the armed forces of the Crown, (b) employment in public departments and (c) employment in public utility concerns, where the Member in charge of the portfolio of Labour certifies that the sick-pay and medical facilities are no less favourable than the corresponding benefits conferred under the scheme, (d) factories in what are termed " Sparse Areas," for which separate provision will be necessary, and (e) private factories, for which under special conditions exception has been granted. These exceptions are mainly necessary on grounds of economy and of need of preserving high-class existing medical facilities, as far as possible.

C. The guiding principles for eligibility will be mainly those of practicability of enforcing payment of contributions, and of affording medical care, prevention of " adverse selection," exclusion of well-off persons, and exclusion on account of special circumstances.

D. For the purposes of the scheme, the workers are classified under " permanent," " temporary," and " casual."

E. The position of different categories of workers, such as *badli* (substitute), unemployed, absent on leave with pay, etc., is considered in this Section. Also the problem of insurance during strikes, etc., is discussed.

F. There will be " exemption " of certain categories of workers, if *they* desire to avail themselves of it. " Exemption " here means exception by application.

G. There will be an upper income limit of Rs. 200 per month. There will be an upper age limit of 60 ; the lower age limit is fixed automatically by the Factories Act at 12.

H. The position of foreign workers working in India will be subject to special rules, implying reciprocity and retaliation.

Chapter III.—Contributions.

A. Certain basic principles have been adopted here : (1) the employer's contribution will be the same for all categories of workers ; (2) there will be no non-contributory class of workers ; and (3) there will be three classes of workers according to the wage-group to which they belong, viz., Class A (earning Re. 1 or more per day), Class B (earning As. 8 or more, but less than Re. 1) and Class C (earning less than As. 8) : and for this purpose only the basic wage will be considered. Only permanent and temporary workers will contribute. The employer will contribute for all workers.

B. The *period* of contributions will be a month, whatever be the wage-period current in any particular area. The *time* of contribution will be within seven days from the date on which liability arises ; liability will arise on the first day for which the worker has been employed during the calendar month. The *structure* of contributions will be as under :—

	Class A.	Class B.	Class C.
	Rs. A. P.	Rs. A. P.	Rs. A. P.
Employer pays	1 4 0	1 4 0	1 4 0
Worker pays	0 12 0	0 8 0	0 4 0
Total ..	2 0 0	1 12 0	1 8 0

As regards the Government contribution, see Chapter IX.

C. The agency for collecting contributions will be the employer.

D. The method of collecting contributions will be the Stamped Card System which is prevalent in most countries, including the United Kingdom, and which is most expedient.

E. Specimens of cards have been obtained and can be adopted with suitable modifications here.

Chapter IV.—Benefits.

A. The basic principles here will be : (1) as far as possible, the benefits obtainable by the worker must be related to the contributions paid by him in the past ; (2) a *waiting period* is necessary in the case of cash benefits, as also a *qualifying period* as in other countries ; (3) the provisions regarding medical benefits should be more liberal than those of cash benefits in the beginning ; (4) there will be " linking-up " of adjacent illnesses for cash benefit purposes.

B. The term " sickness " will have to be very carefully defined.

C. Cash benefit is a vital part of the scheme. It should be sufficient for the maintenance of the standard of life of the poorer workers, but not so much as to encourage malingering. There will be a *qualifying period* of 6 monthly contributions, either continuous or intermittent. A permanent worker will be entitled to a maximum of 90 days' cash benefit, subject to certain conditions ; similarly, a temporary worker will be entitled to a maximum of 45 days' cash benefit. The casual worker will get no cash (but only medical) benefit. There will be a *waiting period* of three days. The scale of cash benefits will be as under :—

Period.	Class A.	Class B.	Class C.
Until the first 6 contributions are paid ..	*Nil*	*Nil*	*Nil*
After 6 contributions and up to the 24th contribution (Partial cash benefit) .. " ..	0 6 0	0 4 0	0 2 0
After payment of the 24th contribution (Full cash benefit)	0 12 0	0 8 0	0 4 0

There will be " linking-up " of two adjacent illnesses according to rules specially laid down.

D. Medical benefit will be given without any conditions as to qualifying period or waiting period, from the first day of illness and up to final recovery, subject to certain rules regarding a " protective period." All insured workers will be entitled to free medical benefit.

E. The worker will be entitled to an adequate measure of skilled medical attendance, but special treatment and hospital treatment will be provided at a later stage.

F. There will be residential restrictions as to receipt of cash and medical benefits ; it is impossible to arrange for either cash or medical benefit, if the worker leaves for his village.

G. There will be a Schedule of Additional Benefits appended to the Act, additional benefits being given at a later stage, funds permitting.

H. Only allopathic treatment can be provided. There will be appropriate rules regarding " behaviour during sickness."

Chapter V.—Financial and Actuarial Aspects of the Scheme.

A. For various reasons, it is felt that the financial organisation of health insurance should be centralised, so as to permit a " pooling of risks " which is the very essence of *social* insurance. This will not, however, rule out actuarial and statistical control, according to different areas, and also decentralisation in the actual day-to-day management of the funds, for which the Post Offices provide a good model.

B. The actuarial basis of the scheme will be the Budgetary Method (as distinct from the Capitalisation Method). The Budgetary method is prevalent practically all over the world, except in the United Kingdom and the Irish Free State. The Budgetary Method is simpler more

economical and administratively easier to manage. On the basis of average expenditure incurred in other countries on the three principal expenditure heads, viz., Cash Benefit, Medical Benefit, and Administration, it appears that 42.5 per cent. of the total collections can be safely allocated to medical benefit, 12.5 per cent. to administration, and the remaining 45 per cent. to cash benefit and reserves. On the advice of the Actuarial Advisory Committee, 40 per cent. is allocated to cash benefit and 5 per cent. to reserves. The Actuarial Advisory Committee are of the opinion that 40 per cent. will support a cash benefit corresponding to 12.4 days in the case of Class A workers, 16.1 days in the case of Class B workers, and 20.7 days in the case of Class C workers. No figures are available to show the probable number of workers in each of the three wage-groups, and an average figure for the supportable sickness rate cannot be worked out, but it may be assumed that of 16.1 days (appropriate to Class B) will be in the neighbourhood of the probable average. In view of the fact that according to data collected the maximum rate of sickness anywhere is 14.6 days per annum per worker, where sick pay or cash benefit was actually paid to some extent, this leaves a considerable margin of safety.

C. The resources of the Health Insurance Fund will consist of contributions from workers, employers and presumably from Governments, donations and gifts, interest on investments, fines and penalties, loan resources arising from the Government Guarantee, other loans raised in the open market, etc.

D. There will be two main Reserves, viz., the Contingencies Reserve Fund and the Epidemic Reserve Fund. The former will be supported by certain resources belonging to the Health Insurance Fund itself, but the latter will be a special liability of the Governments.

E. Disposal of surpluses will be made after actuarial valuation according to certain principles.

F. It is impossible to make any detailed calculations of the probable costs of the scheme. All that can be done at this stage is to provide for an *optimum* rate of contribution on the basis of known data.

G. The Government Guarantee will enable the scheme to remain balanced during periods of deficits. The guarantee amounts to loan facilities from the Governments concerned, repayable later out of surpluses arising automatically or after adjustments in contributions and benefits deliberately made. The provision of a guarantee is an attractive feature of the scheme and should remain, even if the Governments concerned decided to contribute, as the liability on account of the guarantee will not be much and in any case it will be of the nature of a loan-transaction. Detailed suggestions regarding the operation of the Guarantee Account have been made in the text.

H. Accounting and auditing of the Fund will be done by Government auditors and will be subject to the same rules as Government departments.

I. The funds of the scheme should be invested according to certain well-known principles of investment of insurance funds which are discussed fully in the text.

J. There will be an Actuarial Enquiry at the end of the first two years and at the end of every five years thereafter. Apart from these, the Actuarial Branch of the Fund will keep itself fully acquainted with the trend of events.

Chapter VI.—The Administrative Machinery.

A. The kind of administrative machinery most suitable for Indian conditions is one which combines (a) territorial basis, (b) appropriate representation of the contributing parties, beneficiaries and the medical profession, and (c) unification and centralisation.

B. The constitutional position must be considered in this connection. Under the Government of India Act, 1935, "health insurance" falls in Item 25 of the Concurrent List, Part III. In regard to Part II of that List, under Sections 49 and 126 (2), executive authority lies mainly with the Provinces, while the Federal Government's competence is confined to issuing "directions" to Provinces. It will be harmful to split up the scheme into various Provincial schemes. It is, therefore, recommended that a Statutory Corporation should be set up under a Federal Act, on which adequate representation should be given to both Federal and Provincial Governments, as well as to the other parties interested in health insurance. It might be useful to get the Government of India Act suitably amended in the post-war period, so as to permit Federal administration of this as well as other social security measures (which fall in Part II of the Concurrent List), as the Act was framed under circumstances which differ from those prevalent today and also adequate guidance was not available from foreign constitutional models.

C. The structure of the Statutory Corporation, to be styled as the Central Board of Health Insurance, will be *pyramidal,* with the Central Board of Health Insurance at the apex and advisory Regional Boards and Local Committees below. For administrative convenience, the country will be divided into Regions, which, in the case of major Provinces, will be the same as Provinces, while in others combinations of Provinces.

D. The Central Board will consist of 24 members, representing the Government of India, Provincial Governments (and States, if they join), employers and workers, the medical profession, and certain other non-official parties. The Member in charge of the portfolio of Labour will be the Chairman of the Central Board. The Board will constitute itself into two main Committees (Executive and Medical) and sub-committees for different purposes. The Regional Boards will consist of 15 members each, representing the Provincial Government or Governments of the Region, employers, and workers, the medical profession and certain miscellaneous interests. The Regional Boards will be advisory bodies to assist the executive officer of health insurance for the

Region. There will be a Local Committee for each health insurance Centre or Sub-Centre, along similar lines, to assist and advise the local officer of the Fund.

E. The Central Board, the Regional Boards and the Local Committees will have appropriate functions to perform.

F. The industrial areas will be classified under four Classes, viz., Class I Areas, having a large and compact industrial population, Class II Areas of an intermediate type, Class III of a small size, and Class IV Areas (Sparse Areas). The last Class of Areas will be excluded from the scheme. For the first three, there will be respectively Health Centres, Dispensary Centres and Panel Centres.

G. The personnel and functions of the Central, Regional and Local Offices have been described.

H. Detailed suggestions for scrutiny of claims have been made.

I. The Propaganda Branch will have to carry on a campaign for dissemination of information, to workers and others, both before and after the scheme is launched, so as to educate them in the rules of insurance.

J. The Actuarial Branch will be acting as the watch-dog of the scheme, analysing all relevant data so as to enable the Central Board to control waste.

K. There will be inspection of industrial establishments with a view to enforcing the provisions of the Act.

L. The financial aspects of the administrative machinery cannot be visualised until the precise number of Centres and Sub-Centres to be opened is known. This will be done by the Central Board in due course.

M. Though the art of health insurance is not a very technical subject, it might be necessary to train the requisite personnel. In the beginning, however, provisional arrangements will have to be made.

Chapter VII.—The Medical Organisation.

A. The scheme must remain one and indivisible. Separation of the Cash Benefit side from the Medical Benefit side of the scheme has been seriously suggested, but such separation is undesirable. The reasons are : firstly, that correct and reliable certification can be best secured under a unified system ; secondly, that special efforts can only be made by a medical service, which is part of the scheme, to control and reduce sickness incidence, in a manner which cannot be expected of a general medical service ; thirdly, that the problems of industrial medicine are somewhat peculiar and specialisation of medical men is necessary ; and fourthly, that a service which caters specifically for industrial workers is likely to meet their grievances much more satisfactorily than any outside organisation, howsoever efficient. For a *limited* scheme, like the present one, moreover it is essential that the two main parts of the scheme should be linked inseparably.

B. The case for a Salaried Medical Service is stronger than for a Panel Service owing to various reasons fully stated in the text, but it is felt that some sort of amalgam between the two systems appears to be feasible where on grounds of economy the panel system is more convenient.

C. The average number of insured workers in the charge of each medical officer will have to be decided later. The scale of remuneration should not be niggardly and there should be three or four grades of medical officers. Qualifications necessary for posts in the Industrial Medical Service for health insurance should include, among other things, a knowledge of industrial medicine and surgery. In addition to medical officers concerned with medical treatment, there will be Medical Supervisors and Sick Visitors. Panel doctors in Class III Areas should be paid on a capitation basis, by reference to the number of insured persons on each doctor's list, the number being subject to a maximum. As regards buildings and equipment, suitable arrangements will have to be made in the beginning with existing institutions, or houses rented for the purpose ; some proportion of expenditure on capital items can, however, be incurred from Reserves. In panel centres, supply of drugs and appliances will be had from private licensed chemists' shops, subject to special regulations.

D. It is difficult to say in advance what would be the total costs of medical benefit and administration, and this has not been attempted. But it appears that 42.5 per cent. of the total collections should be adequate for the purpose, in view of two estimates of per capita expenditure available to me (one, of the Bombay Textile Labour Enquiry Committee and the other supplied by the Surgeon-General, Bombay) as also in view of the average expenditure incurred in other countries.

E. Rights and duties of insured persons are detailed.

F. Certification and medical reference are described.

G. The nature of treatment that a doctor is required to give is described.

H. Sick Visitors will verify sickness, in sampled cases, in the case of claimants for cash benefit, subject to supervision of Medical Supervisors.

I. Medical Supervisors will be appointed for the different Divisions or groups of Centres, whose functions will be mainly to maintain uniform standards, inspect drugs and other stores, hear complaints relating to medical matters, control Sick Visitors, and supervise medical facilities in " Sparse Areas ".

J. Post-medical rehabilitation is a necessary item in the programme of health insurance as in that of Unemployment Insurance.

K. Preventive activities are likely to be of great financial interest to the scheme. These should be carried out by the health insurance medical service in collaboration with the other medical authorities.

L. Medical treatment of women workers requires special provision.

M. Non-allopathic treatment cannot be provided under the scheme.

N. Medical research, especially in Industrial Disease, will be an important function of the entire medical organisation to be set up.

O. A very controversial question is that of the existing medical facilities provided by the employers. Under the scheme, it should be possible to " except " some of the first-class schemes, subject to certain conditions. In some other cases, it may be desirable to take over by purchase dispensaries and hospitals, if the employer is agreeable. But in most cases, the medical facilities for intra-factory purposes are hopelessly inadequate, and it may be necessary to prescribe better standards of medical treatment of the first-aid and emergency variety, under the Factories Act, than are available at present.

Chapter VIII.—The Judicial Machinery.

A. Disputes may arise on several scores and between different parties. Care has been taken to minimise these. The main types of disputes are : (i) disputes regarding scope ; (ii) disputes regarding contributions ; (iii) disputes regarding benefits ; and (iv) disputes regarding administration of insurance.

B. The more important *offences* which can be committed in relation to health insurance are in regard to (i) enforcement, (ii) payment of contributions, (iii) obstructions, (iv) illicit benefits, (v) fraud and falsification of accounts ; (vi) irregularities of administration ; and (vii) false certification. Punishments appropriate to these have been suggested in the text.

C. Legal machinery for dealing with disputes and offences will consist of two parts : (a) bodies internal to the scheme, viz., the Local Committees, the Regional Boards and the Central Board, according to the relevance of the matter, and (b) bodies external to the scheme, consisting of Special Courts created by the Government of India for hearing appeals.

D. Special regulations will have to be framed for dealing with the problem of decisions on doubtful points, along lines of the Decision of Questions Regulations, 1937 (England and Wales).

E. Certain miscellaneous matters are discussed in this Section.

Chapter IX.—Miscellaneous.

A. The question of a *State contribution* to health insurance cannot be shirked. In the first place, the general proposition that the State should bear its due share of financial responsibility in regard to Social Security, as a whole, is one which needs little argument. Health

nsurance combines income security with medical care. In regard to medical care, the State's responsibility has been already accepted by the Governments in India. In regard to income security during spells of sickness, the trend of practice all over the world is in favour of State participation. The State is fully justified in making contributions from the general revenues for the benefit of a particular section of the population ; in fact, every public budget is a patch-work of nicely balanced measures like this, which involve grants-in-aid or subsidies to particular sections, classes, groups and even institutions. Social security measures are meant for the poverty-stricken masses, just as a country-wide health programme is meant for the diseased and unhealthy. The poverty-stricken masses fall into two broad groups : the industrial workers and the landless agricultural proletariate. Health insurance here is meant for industrial workers ; but surely the State is free to devise medical assistance, with or without income security, for the agricultural working classes. The Government of India comes into the picture of health insurance in a triple capacity, viz., as employer of factory labour in Government factories, as the Government of Centrally Administered Areas, and as the Central Government. Provincial Governments come in only in a double capacity as employers and as Provincial Governments. A half of the medical expenditure, a half of the administrative expenditure, and one-tenth of the cash benefit can be fairly allocated to the State in India. These correspond respectively to 21.25 per cent., 6.25 per cent., and 4 per cent. of the total collections, i.e., 31.5 per cent. in all. Assuming an average contribution per worker of Rs. 1-12-0 per worker per month, 31.5 per cent. corresponds to about As. 8 per month per worker. Of this amount, the Government of India should contribute As. 2 per worker per month, and the Provinces the balance of As. 6 per month. Whereas, the Government of India will have to contribute for all the workers in the country, the Provinces will contribute in respect of workers insured in their respective jurisdictions only. Assuming an initial insured population of 12 lakhs of workers, the total amounts involved are Rs. 18 lakhs per annum for the Government of India and Rs. 54 lakhs for all the Provinces taken together. If the Governments concerned agree to contribute, the employer's and worker's contributions should be adjusted as below :—

Contributing party.	Class A.	Class B.	Class C.
	Rs. A. P.	Rs. A. P.	Rs. A. P.
State	0 8 0	0 8 0	0 8 0
Employer	0 14 0	0 14 0	0 14 0
Worker	0 10 0	0 6 0	0 2 0
Total ..	2 0 0	1 12 0	1 8 0

B. Maternity benefit is closely connected with health insurance, and in many countries it is part of a health insurance scheme. The Royal Commission on Labour envisaged the possibility of such amalgamation in India. Actually, in India, there are several Provincial

(and State) Maternity Benefit Acts in operation, but it is doubtful whether they have been successfully enforced. Maternity benefit, according to the Havana Code, is a fit subject for insurance. This should be done in India and there should be a scheme for Maternity Benefit insurance, which should unify the existing measures on insurance lines and also co-ordinate medical treatment with health insurance.

C. There can be no gratuity or bonus in health insurance, although a worker with a good record of health may be permitted a " protective period " after leaving the Fund.

D. During strikes and lock-outs, the worker should be regarded as " unemployed " for the purposes of the scheme.

E. In the case of " contract labour ", the Principal Employer (and not the Intermediate Employer, i.e., contractor or sub-contractor) should be held liable for payment of contributions and other responsibilities.

F. Special rules for provision of equivalent sick-pay and medical facilities will be necessary in the case of " Sparse Areas ".

G. Holidays with pay and health insurance have different purposes in view, and both will be necessary side by side. During holidays with pay, both employer and worker will pay contributions, but if any worker falls " sick " during such holidays, he can get only medical benefit.

H. Special rules are necessary establishing the precise relationship between Workmen's Compensation and health insurance. These are suggested in the text. The view is also expressed that the time has come to scrap the present Workmen's Compensation Act, the working of which has been far from satisfactory, and to replace it by a scheme for insurance against Industrial Disability along non-commercial lines. This is necessary, both in the interests of health insurance and of workmen's compensation.

I. A " time-table " for putting the scheme into force, consisting of seven main stages, has been described in the text.

J. Extension of the scheme to other industries and occupations may have to be considered later. Its extension to Commerce is more feasible than to Agriculture.

K. An important question is as to what should be the position of the Indian States in regard to the scheme. It is necessary that health insurance should be adopted in the States, where conditions are practically similar to those in British India. States may, however, prefer to have their own schemes, though it may be safer for them to join an all-India scheme. In any case, even if they join, in view of the comparatively low standards of administration of labour laws in some of them if would be better if the case of each State is considered carefully by the Central Board before such a step is permitted.

CHAPTER I

INTRODUCTION

A. THE CONCEPT OF SOCIAL SECURITY

With the declarations of the various peace-aims of the United Nations, of which the Atlantic Charter has been the chief one, Social Security has acquired a new meaning and a new emphasis. Sir William Beveridge, one of the High Priests of this new movement, has thus defined the import of this concept : " Organisation of social insurance should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security ; it is an attack upon Want. But Want is one only of five giants on the road of reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness." (*Report on Social Insurance and Allied Services*, para. 8). This attack on the Five Giants has been otherwise explained by another writer. (Geoffrey Crowther, quoted by J. B. Condliffe, *Agenda for a Postwar World*, p. 97) in the following words : " The ' National Minimum ' (as social security has come to be called in England) involves that the citizen of a democracy should be guaranteed as of right, enough food to maintain him in health. He should be assured of a minimum standard of shelter, clothing and fuel. He should be given full and equal opportunities of education. He should have leisure and facilities for enjoying it. He should be secured against the risk of unemployment, ill-health and old age. Above all, the presence of children should not be allowed to bring with it misery for the parents, deprivation for the children, and poverty for all. All these things inhere in the individual as his citizen's rights." An American expert committee goes still further and defines the concept as covering a wide field : " security for employment (education, employment offices, resettlement and soil-conservation programs) ; security in the availability of employment ; security in employment ; security of income while employed ; security of reasonable standards of working conditions ; security of some income while unemployed ; security of retirement income ; of recreation ; of self-improvement and self-development ; of medical and hospital assistance ; security of one's family in case of one's accident, invalidity, ill-health, or death." Social insurance is just one branch of social security and health insurance is a branch of social insurance.

In India, the beginnings of social insurance date from the passing of the Workmen's Compensation Act and the various Maternity Benefit Acts in some of the major Provinces and States. But, both these measures, being based upon the principle of employer's liability, fall short of the true ideal of *social* insurance, and as a consequence, as will be shown later, have failed to provide complete security to the workers concerned. Health insurance, on the other hand, can be regarded as the first and probably the most important item on the agenda of social security in India. That maintenance of the worker's health should enjoy priority of consideration in this country is also the view of Sir William Beveridge, who recently stated in a broadcast talk that " On the whole, I think I would begin by applying social insurance in India, where we began it in this country (i.e., Great Britain)—to sickness, to providing an income for sickness and treatment for sickness." (Fourth Talk in the B.B.C. Series : " India and the Four Freedoms " : Freedom from Want—2). In this connection, Dr. Rebagliati observes as follows :—

" Of all the occupational and social risks covered by compulsory insurance that of sickness undoubtedly possesses the greatest social interest. The reason lies in the constancy of its incidence, the selection of its victims among the economically weaker sections of the population, its influence on invalidity and premature death, and its

effects on the economic and social life of the community. Insurance becomes even more valuable, where disease runs rampant in the favourable atmosphere of a country with small medical resources and a low biological standard. For the workers, sickness is the principal risk. It is the origin of physical deficiency and economic misfortune. For this reason, it is given first place in the insurance scheme, which uses its best resources to overcome the effects, to prevent the spread of sickness and to strengthen the powers of resistance." (*Vide, International Labour Review,* July 1942, p. 92).

B. The Problem of Health Insurance in India

Unfortunately, although, health insurance has had a rather long history in this country (the discussions started as early as 1927,—*Vide* Appendix VII), the progress of the proposal has been slow. We need not go into the causes of delays that have taken place ; what is significant is that in the last two or three years the pace of events has been so fast that many notions which were partly responsible for the delays, are becoming rapidly out-of-date. With the acceptance by the Tripartite Labour Conference, 1943, of the need for a programme of Social Security for Indian labour in the postwar period, it may appear that the fulfilment of the promise of health insurance would be an early event.

The case for health insurance of Indian workers has been stated so well by the Royal Commission on Labour in India (*Report*, pp. 243-269) that I can do no better than cite the following observation of theirs :—

"The question of making provision for workers during sickness, even if it had not been previously raised by Government, would have been forced on us by what we found in every industrial centre. Of the great need of the workers for something of this kind there can be no doubt. By common consent the incidence of sickness is substantially higher than in Western countries : the medical facilities are much less adequate, and the wages generally paid make it impossible for most workers to get through more than a very short period of illness without borrowing. Indeed, sickness is an important contributory cause of indebtedness, with all that debt entails under existing conditions ; for often, at this time of greatest need, the worker may find himself destitute of resources, unable to take proper measures to restore his health and in difficulties regarding even the means of subsistence. The situation calls for the exploration of all methods that may lead to the alleviation of the existing hardships."

The wide extent of sickness among workers could be illustrated by quoting a plethora of facts and figures, which have become a commonplace of literature on labour. The prevalence of diseases and epidemics, the high incidence of general, puerperal and infantile mortality, the low expectation of life of the worker as of the population as a whole, his miserably low standard of life, the lack of sanitation and proper housing, the evils of mal-nutrition, illiteracy and indebtedness,—all these and many more of the hydra-headed problems have been stated over and over again by official committees as well as non-official bodies. I do not wish to encumber the pages of this Report by repeating those well-known facts, but would like to address myself to two very relevant points bearing upon the question of health insurance. Firstly, even accepting the position that the problem of industrial health is extremely serious, does it necessarily follow that, in the case of India, health *insurance* is the best method of attacking it ? Secondly, and this question partly hangs on the first one, why should the industrial worker be regarded as entitled to a discriminatory treatment in regard to health, as compared to the ordinary citizen ? As regards the former question, it may be recalled that recently the Government of India appointed a Committee under the chairmanship of Sir Joseph Bhore to investigate problems relating to public health in India. In that connection, as part of a comprehensive programme, the special problem of industrial health would naturally have to be considered by that Committee. However, I do not see that there would be any necessary overlapping or duplication as between the general health programme to be recommended by the Committee and the special programme recommended here. In the first place, if and when the

bigger national health programme materialises, it would be quite feasible to co-ordinate the medical part of the present scheme with it, as has been done in Russia and is proposed to be done in the United Kingdom. Secondly, there are some special advantages in adopting the insurance method in the case of industrial labour. As was pointed out at the Second and Third Labour Ministers' Conferences, the problem of sickness in the case of the worker was complicated by *loss of income*. In view of this, *some mechanism is necessary to secure the worker against Want during spells of sickness, and it is impossible to seen how this could be done by mere provision of medical treatment.* In fact, the function of health insurance is regarded as threefold, involving (i) Restoration, (ii) Prevention and (iii) Compensation. As the I.L.O. publication, *Compulsory Sickness Insurance* (p. 14), puts it, " Insurance should no longer confine its efforts to meeting the needs which arise from the weakness of human constitution ; it must pursue the evil to its origin and no longer accept sickness as a risk which cannot be averted. Insurance benefits must look to the source of disease and not merely to its consequences. Their final object is not assistance but the creation of new productive capacity." Apart from this, the sick person must be maintained at his customary standard of living and must therefore receive a cash benefit which is related thereto but which is not so high as to encourage malingering. This is necessary not only from the humanitarian point of view but also from that of keeping " sickness " incidence down. Moreover, industrial workers, in so far as they are employed in organised and regulated industries, are more amenable to the use of the insurance mechanism than, for example, agricultural workers can be. As regards the second question raised above, as to why the industrial worker should be treated difficulty from the ordinary citizen, there are various considerations. In the first place, the industrial worker is more liable to disease and invalidity than the average citizen, and by common consent the rural population is more healthy. Secondly, as compared to a large number of non-industrial urban workers his earnings are low, while as against clerical workers, again, he is exposed to disease and invalidity to a greater extent. Thirdly, if it is desired to extend the principle of insurance to the non-industrial classes, there can be no objection in doing so, but there is no reason why the absence of health insurance for such classes should be a bar to a mainly self-supporting scheme like the present one. Finally, the existing medical facilities provided by various parties, such as the Provincial Governments, local bodies, charitable institutions, and employers are so inadequate in relation to the requirements of the population as a whole that one cannot understand why we should grudge ourselves such extension of medical facilities as this.

C. Earlier Proposals and Existing Schemes of Health Insurance

We may consider here *en passant* some of the earlier schemes proposed for health insurance of industrial workers in India. The contents of these have been given in Appendices VIII-X. In 1931, the Royal Commission on Labour (*Report*, pp. 268-9) proposed a tentative scheme to be put into operation for the time being, until " a more complete scheme could be devised," based upon detailed statistical material. Under this scheme, they proposed : (i) that the responsibility for the medical and for the financial benefits should be separated, the former being undertaken by Government " possibly on a non-contributory basis " and the latter being administered through employers on the basis of contributions by themselves and by the workers ; (ii) that the cash benefit should be supported by contributions from the worker, deducted from the wages, and the employer, in equal amounts, " or rather more (from the employer) in the case of the more poorly paid " ; (iii) that there should be a qualifying period of one year ; (iv) that refund should be made available to workers who

left employment after subscribing and before they had been covered by the insurance for a reasonable period ; (v) that the maximum limit for sick leave (i.e., period of cash benefit) should be one month in the year ; (vi) that the cash benefit should be a proportion of the wages and should be paid by the employer ; (vii) that there should be supervision and audit of funds by the State ; (viii) that in proportion to the soundness of the fund, the annual period of sick leave might be increased or decreased ; and (ix) that the organisation of the funds should be based upon single establishments, where they are large enough, and where they are small on combinations of them. These were the main features of the scheme. Looking at the scheme as a whole, I feel that it was mainly of the nature of an *obiter dictum*, as the Commission could not have been expected to devote much of their time to rationale and detail, in view of the fact that they had to deal with innumerable topics of great importance in their monumental report. Further, we must remember that the scheme proposed was only a " tentative " one to function as a stop-gap arrangement until the necessary statistical material was collected and it was possible for a " more complete scheme to be devised." The main question raised by the Commission in their tentative scheme was that of the administrative separation of cash benefit from medical benefit. I shall discuss this question at length in Chapter VII. Here I may be permitted to state only that I am not in favour of such separation, for in the special circumstances obtaining in this country such a step would be financially disastrous. If, on the other hand, it was the idea of the Commission that the State should bear the major part or whole of the cost of medical benefit, such financial separation or allocation would be quite in consonance with administrative unification of the two main branches of health insurance as proposed in the present scheme.

The scheme proposed (in 1941-2) by the Labour Department of the Government of India (*vide* Appendix IX) was also a tentative one and also preliminary to a comprehensive scheme. Unlike the Commission's scheme, however, here there was no suggestion of separation of the two sides of insurance, both being managed by the employer on a single-unit basis, separately for each concern. The main feature of the scheme was its provision of a non-contributory class of workers for those getting less than As. 13 daily. The question of a non-contributory class will be considered by me in Chapter III ; it may be mentioned here that I do not propose a non-contributory class in the present scheme, but only a special class of low-paid workers paying a nominal contribution. Other features of the scheme were : (i) appointment of medical officers and provision of medical treatment by employers ; (ii) duration of cash benefit to be 15 days, at half daily wages subject to a minimum of 8 annas a day or 3|4ths of daily wage whichever is less, and a maximum of annas 12 ; (iii) contributions at the rate of 0-0-9 for each complete Rs. 5 of wages drawn within a month subject to a maximum of annas 6 in the case of those drawing Rs. 50 and of As. 9 in the case of those drawing more than Rs. 50 ; (iv) half benefit to be paid by employer, excess of receipts over half the sum paid as benefit being funded for the purpose of lengthening the period of benefits ; and (v) maintenance of accurate accounts and statistics by the employer. Medical certification by a medical officer appointed by the factory was rightly regarded by the framers themselves as " clearly open to objection, particularly perhaps in the non-contributory part of the scheme." To hand over the entire scheme to employers would have given rise to serious anomalies and conflicts, in spite of supervision and audit by the State, which was perhaps implicit in the scheme. Other points of the scheme were merely points of detail.

The third important suggestion for health insurance came from the Bombay Textile Labour Enquiry Committee (1940). The main features of the Bombay scheme were : (i) restriction of the scope to permanent workers of the cotton

textile industry in the beginning ; (ii) management by a Board of Management consisting of representatives of the Provincial Government, local bodies, employers and workers, and the medical profession ; (iii) administrative expenditure of the Board to be borne by the Provincial Government ; (iv) free medical treatment without a qualifying or waiting period, cash benefit for a maximum of six months in a year beginning from the fourth day of sickness, to the extent of 75 per cent. of the average daily wage, and additional benefits in the future, funds permitting ; (v) contributions by employers, workers and Government at the rate of As. 10,; As 5 and Anna 1 per month per worker ; (vi) adoption of the panel system of medical attendance under the control of the Board. Here, again, there was no separation of cash from medical benefits, both being under the control of the Board directly or indirectly, panel doctors being appointed as well as dismissed by it. In the present scheme, I have suggested an amalgam of the salaried service and panel principles in providing medical benefit, as will be seen in Chapter VII, where full reasons are given for rejecting a cent-per-cent panel system. Secondly, the Bombay scheme proposed a centralised system with a single and unified fund, a feature which is also to be found in the present scheme, Thirdly, the Bombay scheme suggested a moderate contribution (howsoever small) by the Provincial Government, the administrative expenses of the Board being also borne wholly by the latter. This provided a welcome ballast to the finances of the scheme.

In the questionnaire regarding statistics of sickness incidence, I had called for detailed information regarding any private schemes of health insurance that may be already in existence and regarding leave with pay during periods of sickness, or medical benefit, as also for statistics of sickness experience. Statistical and factual data received from employers have been summarised in Appendix VI. Only the Bata Shoe Company, the Indian Copper Corporation of Ghatsila and the East India Tramways Company of Karachi seem to have any full-fledged and balanced schemes of health insurance. The members' contribution to the Bata Workers' Sickness Benefit Fund is graded according to their salary. The Company also makes an equal contribution in respect of every member. In the Indian Copper Corporation scheme, however, only the workers make any fixed contribution and that also is graded according to wages. But the statement of receipts and payments on account of the scheme, for several years, reveals that the total payments for sickness and injury are about three times as much as the total receipts, which might mean that the contribution by the company was probably twice the workers' contribution. In the East India Tramways Company, Karachi, the workers contribute 1 pie in the rupee of their wages and the company makes a contribution of about two-thirds of the employees' contribution. The average sickness experience (net rate) in the Bata Shoe Company and the Indian Copper Corporation is respectively 8.10 and 10.94 days per worker in the year ; and that in the East India Tramways Company, 2.70 days. In the Delhi Cloth Mills and the Lyallpur Cotton Mills the workers contribute at a flat rate of 2 annas a month. In the Empress Mills at Nagpur there is a scheme under which the worker-members contribute from 4 to 8 annas per month. But out of a total labour force of 17,000 only 21 appear to be on the rolls as members of the scheme ! Many other industrial concerns have provision for sick leave with pay and free medical treatment for their employees. In some of them the leave rules are very liberal, e.g., in the Assam Oil Company, Digboi ; the Buckingham and Carnatic Mills, Madras ; the Bangalore Woollen, Cotton and Silk Mills ; the Salem-Erode Electric Distribution Company ; the Tinplate Company of India ; and the Tata Hydro-electric Generating Stations. The facilities for medical aid provided in some concerns are commendable, as, for example, in the Tata Iron and Steel Company, Jamshedpur, and in the Madura Mills.

D. Difficulties—Real and Imaginary

It is fully realised that the difficulties in the way of introduction of health insurance in India are great, but those difficulties are not insuperable, especially in view of the fact that health insurance as envisaged by the Government at present is of a somewhat restricted application. It is necessary to bestow the maximum possible care upon the drafting of legislation and upon the administration of the Act and in the initial stages at least, the experiment must receive the moral and material support of all the parties concerned. Another thing which may be mentioned in this context is that whenever any scheme of Social Insurance is put into force for the first time, there arises considerable dissatisfaction amongst the various parties concerned with the working of the scheme, viz., employers, workers, and doctors. Practically from every quarter we may expect a barrage of complaints of various kinds. It is not necessary, however, to get unduly frightened by this. The complaints are the natural consequence of the very novelty of the measure and arise from several causes such as (*a*) ignorance regarding the scope of the scheme and its rules, (*b*) initial mistakes committed by the Fund's officers as well as by others, (*c*) some degree of administrative confusion, and (*d*) even perhaps a possibility of the scheme being in some details found incongruous or inappropriate in the light of actual experience, which it is impossible to forecast even for men endowed with the best vision and foresight. It would be possible, however, to minimise the number of occasions for such complaints by means of various measures, such as education of the various parties, including the Fund's officers, in the technique and practice of health insurance, and amendments and improvements in the law itself in the light of the experience gained. Finally, I may mention here the well-known tendency in health insurance for the "claims experience" to shoot up in the first few years of the working of the scheme owing to various causes. Even this contingency need not frighten us unduly. At the most, it will necessitate the introduction of further safeguards to prevent malingering or collusion and also the adoption of preventive health measures in the areas concerned.

Apart from these difficulties, which are more or less of universal application, in the case of India, certain special objections are advanced by the critics of health insurance, which require careful consideration. I discuss these below *seriatim*.

(1) *Objection of inopportune time.*—It has been suggested that a scheme like this will be inopportune (i) in the existing industrial conditions and (ii) in the post-war period when industry would have to withstand foreign competition. Let us consider this objection. If the scheme is introduced during war-time, the industry should certainly be able to stand the slight burden of employers' contribution to health insurance, in view of the gargantuan profits which are being reaped by industrialists at present. In any case, it is impossible to imagine that the post-war period or any other period would be better than the present one. If, however, the scheme is, as is more likely, introduced in the post-war period, the capacity of industry to bear the slight additional cost cannot be any less than during any other normal period. As regards foreign competition, this will no doubt be taken into consideration by any machinery set up for the purpose of granting protection to the old and new industries by means of tariffs or subsidies. If, however, social security measures are to be a part of the post-war economic programme, it is futile to argue against an isolated measure on this ground. A responsible Government adopting such a programme will no doubt take care to see that the position of the industries concerned is not vitiated thereby. Finally, the *gradual* character of the scheme as presented here should enable industry to adjust itself to the new situation.

(2) *Objection that existing schemes and benefits are adequate.*—It has been objected that the scheme is quite unnecessary in the case of areas or industries in which medical attendance and amenities are already provided on a scale approximating to, if not exceeding, the extent of the benefits which would be derived ultimately from a health insurance scheme, and that there is no point in merely putting a Government label on to schemes already sponsored by commercial undertakings and in regular operation. While it is realised that there exist first-class schemes of the type mentioned above in some undertakings, one cannot be sure that either areas or industries, as a whole, provide equivalent amenities. It would be, therefore, impossible to exempt whole areas or industries from the operation of the scheme. On the other hand, exemption of a more specific character to meet the above objection has been suggested elsewhere (*vide* Chapters II and IX).

(3) *Objection that piecemeal proposals upset industry.*—One important objection raised by employers has been that piecemeal proposals of this kind upset their calculations and that it would be more desirable to consider together all proposals regarding social and labour legislation, so that a full appreciation of the financial commitments of all such measures could be made. This objection is likely to be met in fact by the synchronisation of social security measures which will, in all probability, be available under the bigger programme now envisaged by Government in pursuance of the Social Security resolution of the Tripartite Labour Conference, September 1943. But, even if such synchronisation does not materialise, one can hardly object to the prior introduction of any one measure like this. For one thing, historically speaking, in no country has a simultaneous introduction of all labour measures ever been attempted or achieved ; for another, the objection is counter-balanced by the need for gradualness stressed by many others.

(4) *Difficulties arising from the character of Indian labour.*—There is another set of objections raised which go to the character of Indian Labour rather than to the intrinsic difficulties of Health Insurance. It is stated that Indian labour being of a floating and migratory character is not amenable to social insurance of any kind. There are three answers to this objection : In the first place, the floating and migratory character of labour is itself, to a large extent, a consequence of the absence of social and economic security and, this being so, it is necessary to attack this vicious circle by making town life more attractive and comfortable to the worker. The Royal Commission on Labour, no doubt, expressed themselves (*Report*, pp. 18-20) in favour of maintenance of the village nexus, but obviously they had in view the continuance, for some time at least, of insecure and unhealthy conditions in industrial areas. With the introduction of social security measures on a wide scale, the need of maintaining contact with the village would undoubtedly be diminished, especially in the case of labour drawn from a propertyless class which has no alternative but to seek shelter in agriculture, when conditions in industry become intolerable. Secondly, in recent years in many parts of the country, the industrial worker is in fact settling down in urban areas and has no intention to return to his village. The emergence of this industrial proletariate not only minimises the above objection but has created a new necessity of social security measures. Thirdly, as far as is practicable, an attempt has been made in the present scheme to deal with the special problem of the migrant worker. Similarly, special attention has been devoted to the problem of *badli* and absentee workers. In fact, I think the scheme is calculated, to some extent, to operate in a manner that will actually reduce absenteeism and labour turnover. Likewise, it has been stated that the industrial worker is too poor to contribute to any such scheme, too illiterate to understand its rules of business and its implications,

and too orthodox to submit himself to any medical treatment of any modern kind. These objections are met with by some of the provisions of the scheme. In so far as the worker is poor, this suggests a stratification of the wage-classes, so as to graduate the contributions. The provision of a "non-contributory" class, which has not been accepted in the present scheme for reasons stated elsewhere, is only a matter of degree. Moreover, special care has been taken to see that the worker's contribution is sufficiently low and consistent with his ability to pay. In any case, even in the absence of a scheme, the worker cannot altogether escape the cost of health maintenance, and under the present scheme, at any rate, what he would be getting would be much more than what he has bargained for. As regards illiteracy, care has been taken to make the scheme as simple and as easily understandable to the workers as possible and, moreover, measures have been suggested to educate the worker in the business of health insurance. Finally, the orthodoxy of the Indian worker has been largely imposed on him by the costliness and non-availability of modern medical facilities, and, as experience in industrial towns suggests, the worker is not averse to availing himself of modern medicine. Moreover, the special advantages of such a scheme will be so great that it would not be difficult to overcome the resistance of conservatism. Another line of attack pursued by some critics is that the problem of workers' health cannot be solved by health insurance, so long as there is a large number of other causes complicating the situation, such as bad housing and indifferent sanitation, poor nutrition and a low standard of life. While it may be readily admitted that these factors are operating to the detriment of the worker's health, it would be defeatism to suggest that health insurance should be held up until the other problems are solved. There is no hard-and-fast priority of this kind in social measures ; at the most one can say that side by side these ancillary problems must also be attacked.

(5) *Difficulty of paucity of medical practitioners.*—The lack of a sufficiently large number of medical practitioners has also been cited as a possible difficulty in the way of the scheme. It is not, however, realised that the requirements of industrial health insurance are small, as compared to the total number of registered medical practitioners in India. There are approximately 42,000 doctors in India of whom two thirds are licenciates (*vide* John B. Grant, *The Health of India*, Oxford Pamphlets on Indian Affairs, No. 12, p. 24). The present scheme will not require more than 2,000 to 3,000 wholetime medical men. This number is only a fraction of what exists. Moreover, the availability of doctors, like that of everything else, obeys the law of supply and demand. In view of the present paradox of scarcity of medical practitioners and of the difficulties of doctors in eking out even subsistence incomes, it is clear that the apparent overcrowding in the medical profession will not be alleviated unless new avenues of employment, like the present one, are opened up for the profession. This, again, is another vicious circle which can be only broken by making a beginning somewhere.

(6) *Objection that one area may be called upon to bear the burden of sickness of another area.*—It has been contended by some that for one reason or another the financial burden of paying cash benefits and maintaining medical facilities may be heavier in some areas or industries than in others and that, in effect, the latter would be saddled with the excess of burden in the former. This would be particularly the case if the risks of sickness are pooled in a centralised institution as proposed in the present scheme ; while, if the risks are not pooled but borne by each area separately, this would not be so. Now differential rates of sickness incidence as between different areas might conceivably arise from (*a*) greater malingering, or (*b*) greater ill-health in some areas or industries than in others. The question is largely one of financial

organisation and will be discussed again more fully in Chapter V, but here we may clarify one or two points. As regards malingering, there will be effective methods of checking this, but even granting that there is an unchecked residue of malingering anywhere, there is no reason to suppose that this will necessarily coincide with excessive ill-health in particular areas ; in all probability the " error " may partly be cancelled out as between (*a*) and (*b*) above. As regards actual greater ill-health, available figures do not show that there is any marked difference between urban and semi-urban areas in this connection, which need frighten anyone. Moreover, to some extent, industry-wise sickness rates cut across area-wise rates, and in so far as ownership of concerns is scattered over different areas, there should be some redress. But the main point which needs to be emphasised is that the very fundamental principle of insurance is that risks must be pooled so that they can be borne more easily. Even where the approved society model (as in Britain) is chosen, even where the unit is a life insurance company, it is the healthy, long-lived persons who bear the burden of their weaker and short-lived co-insured. This is the very essence of insurance. What harm is there, then, if the principle of differential burdens is extended from persons to areas or industries ?

(7) *Objection that morbidity statistics are inadequate.*—It has been suggested by some that the inadequacy of statistics of sickness incidence is a great obstacle in the introduction of a scheme of health insurance in India. The question of the statistical basis of the scheme has been threshed out by me in the appropriate place (Chapter V). Here just enough might be said to answer this specific question. From the actuarial standpoint, the availability of reliable morbidity data, relevant to the group to be insured, is no doubt a great aid. However, it has seldom been possible for the sponsors of any health insurance scheme to secure data which would approximate to this actuarial ideal. Even in the case of the British scheme, which is supposed to be the best model of actuarial balancing in this regard, the Manchester Unity table had to be amended in certain respects to make allowances for the particular conditions introduced by the National Health Insurance Act, such as correction for the " waiting period ", for disablement, and for workmen's compensation, as also a general " loading " so as to allow a margin for rise of experience. On the other hand, in several new countries like Japan, and countries of South America, such as Chile, Peru, etc., the schemes had to be launched without the help of indigenous statistical material. In fact, the availability of morbidity statistics is something of a hen-and-egg puzzle : unless a health insurance scheme, complete with cash and medical benefits, is in operation, adequate and reliable statistics cannot be collected, and, at the same time, the launching of such a scheme is greatly facilitated by existing statistics. Sir William Beveridge (in his B.B.C. broadcast in November 1943) stated that he did not think the absence of statistics of sickness was a great difficulty. According to him, " we can only get statistics of sickness by having a health insurance scheme, just as we can only get unemployment statistics by having unemployment insurance." Sickness statistics are, mathematically speaking, a " function " of the definition of " sickness " and the rules and regulations regarding benefits under a scheme. In these circumstances, to insist on correct morbidity statistics as a condition-precedent to the introduction of a scheme would be illogical. The collection of statistics regarding sickness incidence without reference to an actual existing scheme, full-fledged in its content and operation, would be very much *in vacuo*. It was, therefore, a wise decision of the Government of India to drop the idea of an actuarial investigation of the kind suggested originally by the Government Actuary's Department in London and later on by Mr. J. H. Thomas, Superintendent of Insurance (in his Note presented to

the Second Conference of Labour Ministers, 1942, *vide* Appendix XI to this Report). Mr. Thomas's later orientation in this regard that (vide *Proceedings of the Third Conference of Labour Ministers*, p. 45) " a process of ' intelligent guessing ' starting from known facts from other sources " should be adopted, was undoubtedly more reasonable. In providing the basis for such " intelligent guessing." all that would be necessary and possible is to collect sickness data in relation to the existing schemes of medical benefit and (if these are available) schemes of health insurance, howsoever unscientific they might be. An attempt has been made by me to collect such data and I am glad that the Actuarial Advisory Committee are prepared to accept the average 14.6 days per annum per worker which is the highest experience of any concern included in the statistical material presented in Appendix VI, as a basis for starting the scheme. The usual method of proceeding after the basic rate is assumed for this purpose is to " load " it, so as to provide a safety margin for the actual sickness experience, which very often shows a sudden spurt owing to legal and psychological factors. This method has also been adopted. I have assured myself that there is a sufficiently large margin of safety in this regard by means of other checks also. These checks have been explained in Chapter V; here it may be permissible just to refer to them. In the first place, morbidity data collected in other countries have some value as a guide, especially as indicating the lower limits for Indian experience, which must be admittedly higher than the experience of Western countries. The case of Japan may be the nearest approximation to that of India here, and, therefore, special attention has been given to it. Secondly, as explained in Chapter V, I have tried to evaluate the relation between contributions and cash benefits per worker in certain foreign countries, as well as India (under the present scheme) and satisfied myself that the contribution in India would stand a considerably higher sickness rate than abroad. Apart altogether from the above considerations and calculations, I am not sure that the modern trend of social insurance really justifies the meticulous precision which the actuarial science rightly requires in the case, for example, of commercial insurance. In the field of *social* insurance, the application of actuarial principles is limited by two main consideration : firstly, that the " profit " motive is not in view, and, secondly, that the State, whose concern it is to organise social insurance and social welfare and, which represents the general taxpayer, is both in a position and is prepared to fill in the gaps created by any financial disequilibrium. That is, in fact, one of the reasons why in the case of sickness insurance, *par excellence*, the budgetary method is preferred to the capitalisation method. In the present case, the Governments concerned have agreed to provide a *guarantee* for maintaining the financial stability of the scheme. If and when there is also a Government contribution to the health insurance fund, it will no doubt provide an additional measure of stability to the scheme.

E. Assumptions regarding the Future

Although the health insurance scheme as proposed here may be said to be self-contained and complete in itself, there are certain " assumptions " which may be made for the greater success of its operation in the future. These assumptions relate to matters with which the present Report is not directly concerned and which do not fall within its scope. But although it is not concerned with the urgency or importance of these matters *per se*, they must be stated in so far as they affect the present scheme. It is not proposed, therefore, to deal exhaustively with the *pros* and *cons* of each of them in this place but only to indicate their vital connection with health insurance.

Assumption A : Unemployment Insurance and Maintenance of Employment.—The early adoption of a scheme of unemployment insurance, on a restricted basis so as to cover the factory industries which are also subject to this scheme will, to a material extent, facilitate the operation of health insurance. The close connection of unemployment insurance with health insurance is an accepted fact in western countries, and, in fact, it has been even suggested as a condition-precedent to health insurance by many. For example, Mr. James Bacon (at the VIIIth International Congress of Actuaries—*Proceedings*, Vol. V. P. 230) stated :—

"I suggest that in considering the cost of any scheme of social insurance, we must take a very much wider view than that of the cost of any individual benefit or the immediate cost of that benefit. For example, in considering the question of sickness insurance we must not overlook the fact that sickness and unemployment are closely related, and that if there is a system of sickness insurance without unemployment insurance, or if the sickness benefit is much higher than that paid in connection with unemployment, claims for sickness will be higher than if both benefits are in existence and are paid for at the same rate. So it is very necessary indeed, in considering the cost of any system, to consider the matter as a whole and not merely to view the immediate claims."

In the absence of unemployment insurance, there is no doubt that the insured worker, in spite of the various safeguards introduced here, is likely to resort to malingering and this will be particularly true of casual unemployment amongst the *badli* workers. Thus, at least one of the incentives for malingering is likely to be removed if unemployment insurance is undertaken. What should be the objects, methods and scope of unemployment insurance for the workers covered by this scheme, is a matter which falls outside my province, but I do not feel any doubt regarding either the desirability or practicability of such insurance, especially if it is restricted to industrial workers. The other and more important part of this Assumption is the maintenance of existing employment both in its volume and in its continuity. This part of the Assumption implies, firstly, a plan for the creation of new employment, especially in the post-war period when problems of demobilisation are likely to be acute, and, secondly, the provision of adequate machinery for re-employment and rehabilitation. The former depends upon the Government's programme of Post-War Reconstruction, while the latter necessitates the establishment of a country-wide network of employment exchanges, not only for technical personnel but also for unskilled labour. It is a matter of satisfaction that the Government of India have already initiated a programme of action in this direction. In addition to employment exchanges, however, it may be necessary to provide training and re-training facilities for those workers for whom employment is not available in their accustomed lines, so as to facilitate their rehabilitation and placement in peace-time industries and occupations.

Assumption B : Old Age Pensions.—As indicated earlier the age question is bound to be somewhat critical for the scheme. So far as the lower limit is concerned, *viz.*, 12, there is no difficulty, as under the Factories Act, Section 50, the question of lower limit is automatically decided. There is, however, no age restriction on aged workers at the other end. At present, if aged workers are physically unfit for work, they are excluded from factories either by their own choice or by the employer's efficiency requirements. As soon, however, as the scheme of health insurance is put into operation, aged persons are likely to find it more attractive to stick on to their jobs and avail themselves of the cash benefit by understating their age at the very beginning. This tendency will be particularly present among workers of the older age groups in the initial years of the scheme, as well as amongst workers joining an insurable

industry at late ages even in later years. Of course, those workers who have joined at young ages, generally speaking, cannot be expected to take such advantage, and understatement of age will probably be rare amongst them. It may thus be feared that a part of the responsibility which legitimately belongs to Old Age Pensions, will be saddled upon health insurance, to the detriment of the latter. For the same reasons, it cannot be suggested that so long as an Old Age Pensions scheme is not put into operation, its purpose might be fulfilled by health insurance. If it is felt that old workers must be protected from want, we must make a direct approach to the question, and not seek to achieve indirectly and also unsuccessfully, through health insurance what must be achieved directly through Old Age Pensions.

Assumption C : Other Pre-medical Measures.—Apart from unemployment insurance and old age pensions, there are a number of other " pre-medical " measures, mainly falling within the scope of labour legislation, which are vital to the success of health insurance. In fact, all measures of social health and welfare are intimately inter-related and progress can be only substantial if it is all-aided. This implies an integrated legislative policy in regard to labour problems. The pre-medical measures covered by Assumption C are : (i) regulation of wages, (ii) rigorous enforcement of factory laws and regulations relating to hours of work, conditions of work, safety, ventilation, rest-pauses, recreation, etc., (iii) education in health and hygiene, and (iv) improvement of environmental hygiene. The existing labour legislation no doubt tackles some of these problems but a great deal still remains to be done so as to assure to the worker a decent standard of life and proper conditions of work ; and, above all, enforcement of laws is a matter of far greater importance than their mere enactment, especially in a country like India, where the labour force is illiterate, ignorant and hopelessly unorganised. Unless, for example, the Factories Act and Payment of Wages Act are rigorously enforced, there will be serious gaps and loopholes available for unscrupulous persons to defeat the working of the Health Insurance Act. In effect, this means that health insurance will be partly at the mercy of the existing system of labour administration, and this will have to be considerably tightened up so as to prevent evasion and fraud.

Assumption D : A National Health Drive.—The problem of industrial health cannot be treated separately from the general problem of urban health or even national health. The progress made by Provincial and municipal authorities in regard to urban health is still very poor, in spite of the fact that the general foundations of a national health policy were laid down many years ago. As Dr. J. B. Grant remarks (*The Health of India,* Oxford *Pamphlet* on Indian Affairs, No. 12), " In advanced countries public health has now become social medicine, a field of social service directed towards the medical protection of the community and its individuals through organised collective effort." The recent appointment of a Health Survey and Development Committee, under the chairmanship of Sir Joseph Bhore, holds out the promise of such an organised collective effort. The main problem arising from the work of that Committee will no doubt be that of finance. It may be worth while, however, to quote the Royal Commission on Labour (*Report,* pp. 243-4) in this regard : " Expenditure on public health, besides yielding an immense return in human happiness, is bound to produce great economic advantages. There are few directions offering such great opportunities for profitable investment on the part of the State. The economic loss involved in the birth and rearing of great numbers of children who do not live to make any return to the community, in the sickness and disease which debilitate a large proportion of the workers, and in early death, with the consequent reduction of the earning years, is incalculable. Even a small step in the pre-

vention of these ills would have an appreciable effect in increasing the wealth of India ; a courageous attack on them might produce a revolution in the standards of life and prosperity. We feel that the time for inaction and delay is past and that, particularly in regard to housing, it is imperative that an immediate beginning should be made. To those who assert that India cannot afford to spend more on public health, we would reply that she can no longer afford to do otherwise." Even though the programme of action which the above-mentioned Committee would be recommending takes several years to be implemented, still the necessity of co-ordinating the activities of the Health Insurance Administration in this field with those of the general programme will be great and there is no doubt that lasting advantages will accrue to health insurance as a result of the general reduction of sickness in urban as well as rural areas. The national health drive will also imply various ancillary measures of great importance to the health of the industrial worker as to that of the average citizen. In particular, problems of housing in industrial areas, of nutrition and food adulteration, and of industrial hygiene require the closest attention of the Government. As these problems have been discussed threadbare by official as well as non-official bodies and persons, amongst whom mention may chiefly be made of the Royal Commission on Labour, the Industrial Commission, the Central Advisory Board of Health and the Nutrition Research Laboratories of Coonoor, I do not propose to dwell upon them. The only point which may be stressed here is their intimate bearing upon industrial health and hence upon health insurance. It would amount to tinkering with industrial health, if health insurance concerned itself with merely provision of cash benefits and cure of sickness, and did not also participate in a frontal attack on the problems of health and labour welfare at their very roots. It would indeed be foolish to erect a costly superstructure without caring to build it upon a stable foundation, but the national health drive is a responsibility of the State as a whole and not of industrial health insurance only. All that the latter can do or can be expected to do is to play its own part in such a drive.

F. Certain Fundamental Principles.

The present scheme is based upon certain important principles some of which are accepted by insurance institutions in other countries. I regard the principles as fundamental in their significance and as a compass-needle to the framing of the proposals made in the following pages. The principles are stated below in due order.

(1) **The scheme must be a compulsory one, if it is to be of any real value to the working classes.**

It is now universally agreed that the modern State as a guardian of public health has the right to make insurance compulsory, and ought to do so in the interest of the public. As the I.L.O. publication, *Compulsory Sickness Insurance* (M. 6), p. 10, remarks, " In spite of its valuable achievements, the voluntary insurance movement has been found insufficient, and it has become clear that the way to secure general and effective protection against the risk is by making insurance compulsory." A voluntary scheme, which would have special attractions for inferior lives and for married and elderly persons, would require a contribution greatly exceeding that appropriate to a compulsory system and would probably be prohibitive to young persons." In this connection, Sir Walter Kinnear (in his *Report on Health and Pensions Insurance*, Australia, p. 10) observes : " Voluntary insurance is to be highly commended as encouraging individual thrift and foresight, but voluntary insurance cannot cater for the weaker and more helpless elements in the population. The

class of person who most needs social protection is frequently unable to afford it without some assistance from other sources, and, even if he can afford it, often lacks the initiative and foresight to become, and remain, insured." Voluntary schemes, even where they were liberally subsidised by the State, have failed. They have failed mainly because of their limited scope, which led to unsound finance, maldistribution as between sparse and compact areas, and inability to function properly in times of depression. Voluntary insurance implies the ability and willingness of the industrial worker to pay the minimum contribution to the Fund and hence it is not always a safeguard for the family of a worker against his own lack of foresight. It is for these reasons that the I.L.O. Convention requires the States Members to set up a system of compulsory insurance. The Explanatory Report (*vide I. L. Code*, p. 322, footnote 2) states that the advantages of compulsory insurance " arise out of the extent of its scope, which embraces also the weaker members ; the balancing of bad risks by gobd ; the certainty that it cannot be disturbed even by epidemics ; the collaboration of employers, workers, and the State ; and the slow but sure education of the masses of the people, to whom it introduces the idea of the responsibility of communities and individuals in private and public life." It goes on to say that " compulsory insurance sustains the weak, mitigates the bitterness of the struggle of existence, and lessens the cost of poor relief ; it releases the worker from anxious cares ; it raises the level of the health and strength of the people ; it forms an essential part of social hygiene and economic policy."

(2) **The scheme must be a contributory one, as far as possible.**

Since the passing of the German Act of 1883, most of the schemes that followed have accepted the principle that both the worker and the employer should contribute to the financial resources of the health insurance fund. One of the I.L. Conventions regarding sickness insurance lays down that the insured persons and their employers shall share in providing the financial resources of the sickness insurance system (I.L. Code. Art. 503). The contributory principle has not only been recognised as an essential feature of a well-balanced health insurance scheme, but it has attained immense popularity in some countries. Sir Walter Kinnear (*op. cit.*, p. 7) observes : " It is now almost universally agreed that a National Social Insurance Scheme must be on a contributory and compulsory basis. The contributory principle has a value, apart from financial considerations, in that it increases self-respect amongst insured persons, encourages thrift, and by establishing an ' insurance right ' to benefits does away with the necessity for irritating tests as to means and periods of residence." Briefly speaking, financial participation in health insurance arises from *responsibility* in the widest sense for the occurrence of the event insured against, from the advantages received in the shape of benefits and, in general, from the principle of insurance itself. Judged by these standards, it is but proper that both the employers and the insured persons should contribute to the scheme. Health insurance, by keeping labour contented and efficient and by checking such industrial evils as labour turnover and absenteeism, can pave the way to industrial peace. It can also lessen the burden on industry by means of prevention of sickness, improvement in sanitary conditions and relief in regard to medical expenditure. On the other hand, the contribution from the insured person is justified not only because he directly benefits by the scheme, but also because thus alone can he share in the management and claim benefit by right. It is for these and similar reasons that the scheme does not accept the " non-contributory " principle. It insists that however small the contribution may be, every worker must contribute to the Fund. Only this way can he be made to realise the significance of sickness insurance, take a keen interest in its administration and also avail himself of the

benefits conferred by it. The advocates of non-contributory insurance put forward the plea of the precariousness and inadequacy of wages of low-paid workers and also claim that insurance as a public service should be financed out of public funds, as in New Zealand, where social security is financed by a graduated income-tax. In the present scheme, however, the contributions have been purposely kept low, so as to enable the industrial workers to pay them without any great inconvenience ; besides, to provide for the very low-paid worker, a special class has been created for which the worker's contribution is As. 4. As for the argument that the State must wholly finance such schemes out of taxation, it is worth quoting Sir William Beveridge, who, in his B. B. C. broadcast said : " I propose in my Report to keep the contributory insurance scheme that we have established in this country (*i.e.*, in the U.K.) ; it adds to their self-respect. The second, very practical reason, is that if social insurance is financed wholly by general taxation, you lose one very important defence against pressure to pay up the benefits indefinitely, and frankly I want a defence ; I want people to feel that for 40|- a week in old age they pay so much when they are earning. If they want 60|- they must pay 50 per cent. more."

(3) **The scheme must be simple, clear and straightforward, from the viewpoint of those who will administer it, those who will pay for it and those who will benefit by it.**

Simplicity, clarity and straight-forwardness should be the featurs of any insurance scheme. In the case of a scheme applicable to Indian labour, the need for securing these qualities is all the greater, in view of the illiteracy and helplessness of the worker, the peculiarity of labour conditions, and the novelty of the proposal. This does not mean, however, that the scheme and its legal framework can be simplified so as to be mere child's play. If reference is made to health insurance laws and rules framed thereunder in other countries (in particular, reference might be made to the enormous tome of Henry Lesser, *The Law of National Health Insurance*, 1939, which runs into more than 1,200 pages), it will be noticed that the legal framework necessitates great caution so as to avoid financial instability and litigation. An effort has, however, been made in the present scheme to simplify the fundamental conditions of its operation in every possible way. In addition, suggestions have been made to provide for simplified handbooks and guides for the use of workers and others concerned.

(4) **As far as possible, the scheme must take the existing framework of labour legislation as its formal basis, and not attempt entirely new orientations or be repugnant to such legislation.**

This must be done not only for convenience of working the scheme itself but also so as to avoid confusion in the " Labour Code " of the country. In some cases, no doubt, the health insurance law may have to adopt terms and legal notions which run contrary to the provisions of the existing labour laws, but such occasions must be minimised.

(5) **The scheme must not be too ambitious and in the beginning at least must stick to certain well-defined objectives.**

If gradualness is to be the keynote and progress is to be based upon experience, it would be better to stick to a few well-defined objectives in the beginning. This is also necessary from the financial standpoint. Further extension of the scheme can be attempted at a later stage. With this end in view, a " Schedule of Additional Benefits " has been appended, which contains suggestions for extensions (*vide* Appendix XII).

(6) **The scheme must be financially sound, economical in its working and (as far as possible) actuarially balanced.**

It is obvious that to produce an actuarially balanced scheme *ab initio* is an impossible ideal, especially when it is realised that even the matured schemes in western countries have not attained such a nice balance. The difficulties in the case of India are very much greater. But that does not mean that an attempt should not or could not be made to obtain the maximum possible financial stability for the scheme, in so far as this is practicable. In Chapter V, I have fully discussed the methods adopted to achieve this end. The Report of the Actuarial Advisory Committee, which is appended to this Report, I am glad to say, generally approves of the technique adopted. It is premature to say whether there is any actuarial balance in the scheme. This can be decided only after obtaining statistical data through the working of the scheme itself during the first few years. The provision of a Government "guarantee" further safeguards the scheme from any serious disequilibrium, no doubt, but as is explained in Chapter V, the balance has been deliberately tilted in favour of a surplus position so as to provide initial safety. It is apparent that, apart from the other incidental factors, such as administration, supervision and the provision of checks and balances, the morbidity experience of industrial workers is one of the prime factors, which must, together with the scheme of contributions and benefits, decide the financial aspects of the scheme. It is too early to say yet what this will be, but *every care is taken to ensure that the scheme would not cost to the country, including employers, workers and the taxpayers, anything more than what the morbidity experience, in the light of the regulations regarding contributions and benefits, should ordinarily warrant.* On the other hand, excessive tightening-up of the rules may reduce the cost of the scheme but it may also spoil the scheme entirely for fear of losing relatively small sums by leakage.

(7) **The scheme must minimise disputes and litigation and, at the same time, close all loopholes for malingering, collusion and the commission of offences.**

It is necessary that in a scheme like this the law should be as cautious as possible, but, it must not be so watertight as to cause inconvenience or harassment to the parties concerned. In Chapter VIII, which deals with the Judicial Machinery, general directions are given which may be found useful in framing this part of the law.

(8) **The scheme must be workable in the peculiar circumstances of Indian labour and industry.**

Special precautions have been taken in the scheme, to apply the technique of health insurance to the special case of Indian labour, which is migratory, illiterate, ignorant and unorganised. Especially, problems such as those of seasonal migration, *badli* labour, absenteeism, contract labour, etc., required special consideration. These were the obstacles which had held up the progress of health insurance in India. How far the solutions suggested by me meet the situation is a matter of future, but I believe that they are adequate so far as things can be foreseen to-day.

(9) **The scheme must, as far as possible, be in conformity with the International Labour Conventions in respect of Sickness Insurance. (Articles 496—516 of the International Labour Code, 1939).**

The relevant International Labour Conventions have been quoted in full in the *International Labour Code*, 1939, pp. 321-333. The recent Recommendation of the Philadelphia Conference regarding Medical Care was available to me in a draft form. Conformity with these has been aimed at as far as feasible under the special circumstances under which the scheme had to be prepared. Such conformity is desirable for three reasons. Firstly, the Conventions suggest, in many cases, the best and most rational approach to the problems of

health insurance ; secondly, if it is so desired, the ratification of the Conventions by the Government of India (which was rejected in the central legislature in 1928) could be reconsidered at a future date : and thirdly, this would also help uniformity of security legislation from the international standpoint.

(10) The scheme must not be allowed to be inappropriately burdened with financial liabilities which properly belong to other measures of social security, unless, of course, such measures are knowingly incorporated into the scheme.

The purport of this principle is to avoid illegitimate financial responsibilities being passed on to the Health Insurance Fund by various parties. Thus, for example, employers, in some cases, may attempt to reduce their own liability under the Workmen's Compensation Act by making the Fund pay for injuries and industrial diseases described as " sickness." Similarly, workers may seek to obtain cash benefit by malingering during periods of unemployment in the absence of an unemployment insurance scheme, and also obtain illegitimate benefit by understatement of age, in the absence of old age pensions. Where, however, the health insurance scheme has avowedly assumed certain functions, such as provision of maternity benefit, the question of applying this principle would not arise as there could be no surreptitious transfer of responsibility there.

(11) Finally, the scheme must be flexible leaving sufficient scope for subsequent alterations and extensions.

There are numerous possibilities of future extensions and alterations in regard to the present scheme. Some of these have been indicated elsewhere, but the biggest possibility is that of a unification of the various social insurance scheme which may be recommended by the Planning Committee. In framing the scheme, therefore, I have kept an eye on these possibilities. I may further mention here that this scheme is concerned mainly with provision of the framework of the legislation to be prepared in the near future and hence I have not worked out the detailed Rules regarding such matters as collection of contributions, rules of business of the insurance offices and insurance committees, cash benefit and medical benefit, stamping, sick-visitation, valuation, etc. These Rules will have to be prepared immediately after the Health Insurance Act is passed. The Act itself will have to lay down the general principles in regard to these regulations. Except on important questions, therefore, I have tried to keep the scheme sufficiently flexible to enable subsequent changes to be made.

Chapter II.

THE SCOPE OF THE SCHEME.

A. Industries and Occupations Covered.

It was decided at the Labour Ministers' Conferences that in its early stages the scheme should be confined to only a few important industries, so as to provide a basis of experience for further extensions later on. Accordingly, I was instructed to consider only three major industries for introduction of health insurance, *viz.*, Cotton Textiles, Jute Textiles and Heavy Engineering. It was, however, soon obvious that it would be difficult, if not impossible, to define these industries in such a way as to close legal loopholes for evasion. The reason, why the three industries were recommended at the Labour Ministers' Conferences was, of course, that they were well-organised. But the question of organisation was not so relevant as that of legal enforceability. Most of the labour laws are applied without much difficulty to factories covered by the Factories

Act. So the basis of the Factories Act suggested itself as most suitable for hanging the coat of health insurance on the peg of some existing legal machinery, so as to facilitate administration in the initial stages of the scheme. Thus, legal enforceability could be partly achieved by adopting the Factories Act machinery ; but definition of industries for the purpose of classification was a point for further consideration. It appears that the present classification of factories, whether perennial or seasonal, under various groups is not a matter of any serious implications so far as factory administration is concerned, for to factory inspectors all that matters is whether a particular establishment is a factory within the meaning of the Act and whether it is perennial or seasonal. Beyond this the factory law does not differentiate between different categories or groups of factories. The *Statistics of Factories* published from year to year, no doubt, contain detailed classification, but it is I believe, mainly for orderly presentation of figures. It is defficult to define the term " cotton textiles " precisely so as to exclude or include mixtures, or the term " heavy engineering " without taking impossible cross-sections of factories in which heavy and light processes are inseparably mixed up. Nor, for the matter of that, can even an engineer say where " heavy " ends and " light " begins. For these reasons, in consultation with Provincial Governments, it was decided that the scope of the scheme should be extended in the first instance to three major *groups* of industries, *viz.*, all " textiles," all " engineering," and all " minerals and metals," so as to cover the following :—

1. All *Textiles*, including cotton (spinning, weaving and other factories), jute mills, silk mills, woollen mills, and miscellaneous.

2. All *Engineering*, including coach-building, and motor car repairs, electrical engineering, electricity generating and transforming stations, general engineering, kerosene tinning and packing, metal stamping, railways workshops, ship-building and engineering, steel-trunk, lock and cutlery, tramways works, and miscellaneous.

3. All *Minerals and Metals*, including foundries, iron and steel smelting and steel rolling mills, lead smelting and lead rolling mills, petroleum refineries, and miscellaneous.

Under these industries all such establishments as are covered by the Factories Act, 1934, will be brought under the scheme, subject to two exceptions :—

(a) *Seasonal factories*, which will be excluded in the beginning, only *perennial factories* being covered ; and

(b) *Scheduled exceptions*, mentioned in Section B below.

The term " seasonal factory " is defined in Section 4 of the Factories Act. The difinition appears to be satisfactory for the purpose of the present scheme. The exclusion of seasonal factories is considered desirable on two grounds : in the first place, owing to lack of continuous employment throughout the year, contributions will not be regular in such industries ; secondly, it would be safer to build upon the experience of perennial factories, leaving the inclusion of seasonal factories to be considered at a later stage.

Even if the Factories Act is taken as a basis, the classification adopted by factory inspection departments must be regarded as merely *prima facie* guidance in deciding whether a factory is or is not covered. The final issue of inclusion or exclusion in doubtful cases cannot be left to an administrative machinery which has no direct responsibility for administering the scheme. The best course under the circumstances is to empower the Competent Authority (which may be the Member in charge of health insurance) to say whether a factory is covered or not. The most troublesome case is likely to be that of

"miscellaneous" under each group. Apart from this, it is conceivable that certain factories apparently outside the three groups may interest themselves in processes legitimately belonging to textiles, engineering, and minerals and metals. This may be done by the factories either on their own initiative with a view to production of spare and intermediate parts saleable in the general market, or as part of contract work given to them by factories covered by the Act. This might cause some leakage of funds and to that extent the purpose of the law might be defeated. Such cases will arise mainly in the twilight zone of industry, where processes belonging to different industries shade into one another defying classification. If suitable rules are not framed in advance to deal with this, the delimitation of the Act to three groups of industries only may lead to splitting up of processes, and sub-processes may be taken up in factories not covered by the Act. To deal with this situation, the following tentative rules may be suggested :—

1. Whether or not any factory falls in one of the three groups is, a *qusetion of fact* and will be decided mainly by the Competent Authority. If such a factory also carries on processes not ordinarily connected with textiles, engineering or minerals and metals, such processes shall not be excluded from the operation of the Act. This is necessary for the reason that no loophole must be left enabling the factory-owner to shift his workers from insurable processes to non-insurable processes, with a view to evasion of the Act.

2. Where it is a case of contract labour, working inside a factory in a process connected with an industry covered by the Act, provisions suggested elsewhere (in Chapter IX) will naturally apply.

3. But where work is given out on contract to another factory, which is not covered by the Act, and where such work happens to be connected with a process of an industry covered by the Act, and also where any factory in a non-insurable industry engages itself on its own initiative in an insurable process, the rule will be that the Competent Authority will decide in its own discretion that any section of the factory or any group of workers engaged therein will be subject to the Act. In this case, the work being done on or about the premises of the non-insurable factory, naturally the occupier of this factory will be held responsible for contributions. Any fraudulent subterfuge adopted to evade the provisions, *e.g.*, by shifting workers from insurable to non-insurable processes, will be a matter for inspection and prosecution.

B. Scheduled Exceptions.

Certain establishments and certain types of employment will be excluded from the operation of the scheme, partly on the lines of the British National Health Insurance Act, 1933, First Schedule, Part II. The following will be the principal exceptions :—

(a) Employment in the naval, military or air services of the Crown.

(b) Employment under the Crown, or any Provincial or local or other public authority, where the Member in charge of the portfolio of Labour certifies that the terms of the employment are such as to secure provision in respect of sickness on the whole not less favourable than the corresponding benefit conferred under the scheme.

(c) Employment in such other public utility concerns and Government factories as may be certified by the Member in charge of Labour to have fulfilled the same conditions as above.

(d) Where local circumstances make it difficult to combine an isolated undertaking with others on account of distance or any other reason and where such undertaking employs less than 500 workers, the Competent Authority

may except such undertaking from the scope of the scheme until the difficulty has been overcome, subject to the provision that such an undertaking must provide " equivalent " medical and sick-leave benefits as may be prescribed under the Act. (See Chapters VI and IX for discussion on " Sparse Areas ").

(e) Where, on grounds of equivalent facilities, exception is applied for by an employer who has provided adequate standards of cash benefit or sick leave and medical treatment and who has entered into an agreement with his workers, as indicated in Chapter VII, Section O.

The case for exception of Government and semi-Government concerns rests on the following grounds : In the first place, the facilities for medical treatment and sick pay are so widespread and so substantial in the case of some of the Government concerns, especially railways and port trusts, that it would be both economical and convenient to continue these arrangements undisturbed as far as possible, especially in view of the possibility that the Fund itself may not be able to improve materially upon these facilities. Secondly, Government concerns are not run for profit of shareholders or such-like, and even when profits accrue, they only relieve the general taxpayer. Hence there would be no incentive on the part of Government concerns to abuse any privileges granted under the Act. Reference may here be made to I.L. Convention Art. 498 (2), which provides that " Any Member may exempt from the compulsory sickness insurance system persons who in case of sickness are entitled by virtue of any laws or regulations, or of a special scheme, to advantages at least equivalent on the whole to those provided for in this Section." It may be noticed that in the case of Government concerns, the exception is absolute for this reason, and there are no conditions of any kind modifying it, as in the case of private employers. The only safeguard will be that the Government concern desiring such exception will have to apply to the Fund stating the circumstances justifying exception and that the Fund will have to be convinced that equivalence of benefits does in fact exist. If that is not so, the public or semi-public authority concerned may be required to adjust its sick leave rules and extend its medical facilities so as to bring about the necessary equivalence of benefits. The exception however, is *not automatic* and if the Fund's authorities are satisfied that the sick pay medical facilities are so poor that the Government concern will have to start *ab initio,* they may not agree to granting exception or make suggestions for improvement in facilities. If the medical facilities are adequate, improvement in sick pay conditions would be easy, but not *vice versa.* Generally speaking, therefore, refusal to grant exception may result when medical facilities are unsatisfactory. An alternative suggestion, which might be made, is that all Government and semi-Government concerns should be given due notice of say, two years, asking them to provide equivalent benefits, and only after this initial period, the Fund may take a final decision in regard to exception or inclusion.

The question of " Sparse Areas " will be discussed more fully in Chapter VI, Section E and Chapter IX, Section F. That of " Existing Medical Facilities " provided by private employers will be discussed more fully in Chapter VII, Section O.

C. Guiding Principles for Eligibility

The following main principles have been taken into consideration in deciding the eligibility of workers to become members of the scheme :—

1. Practicability of enforcing payment of contributions.
2. Practicability of affording medical care.

3. **Exclusion of workers who will not receive fair protection in return for** their contributions.

4. Reasonable safeguards against " adverse selection ", i.e., in particular exclusion of persons who are not ordinary workers but procure entry to the scheme to obtain immediate benefit.

5. Exclusion of such persons as are, on account of their economic position, well able to take care of themselves (*e.g.*, those above a certain income limit, relatives of employers, etc.).

6. Exclusion of those who for reasons of old age or permanent invalidity must be excluded so as to avoid an undue financial burden on the scheme (such persons must more properly be taken care of under separate schemes of Old Age and Invalidity pensions).

7. Temporary exclusion on account of special circumstances such as unemployment, etc.

D.—Types of Workers.

It is proposed to have the following three types of workers according to the duration and regularity of their work :—

(i) *Permanent* worker—one who has put in 3 months' continuous service.

(ii) *Temporary* worker—one who has put in 3 months' service intermittently in the aggregate in a calendar year.

(iii) *Casual* worker—one who has not completed 3 months' service either in the aggregate in a calendar year or continuously.

The term " worker " as defined under section 2 (6) of the Factories Act, 1934, apparently excludes (a) clerical staff of the factory, and (b) the watch and ward staff, *chaprassis*, peons, gate-keepers, time-keepers, etc. The suggestion has been made that the term " worker " should be re-defined so as to include these two groups of workers. If it is decided to re-define the term, it may be necessary to take into consideration any possibilities of evasion, such as removing the clerical and other staff from the factory, etc. So long as commercial labour, is not covered, clerical workers will be specially liable to be thus transferred. For this reason, I am not very favourable to the inclusion of clerical staff *at this stage*. The case of the latter group, however, is different. This group consists largely of manual workers who cannot be easily shifted outside the factory. The definition, therefore, might include such workers.

The term " continuous service " also will have to be defined precisely. In connection with workers' compensation and maternity benefit, this term has caused much controversy. Much of the difficulty has arisen in the past owing to the fact that no service cards have been maintained in certain factories as also owing to the worker's ignorance. I think matters would be regularised if factories are required to follow the system adopted in western countries where gates and times of attendance are automatically recorded at the gates of factories. The maintenance of proper service cards will also be a safeguard. Some of the Standing Orders in the Provinces have defined the term " continuous service " and it has also been a topic of official discussion lately. The term, therefore, can be suitably defined after considering these various aspects, and it should be possible to adopt a definition, which should be applicable not only to health insurance but to various other labour matters. Here, as elsewhere, the basic terminology of the Labour Code is a matter requiring careful drafting and I am not in a position to dogmatise.

It was suggested to me that the scheme might be applied immediately to all those workers who have been in continuous service for some time before the

passing of the Act or the introduction of the scheme. I am unable to accept this suggestion, firstly, because this would lead to lack of uniformity of treatment in places where there is no proper record of service, and, secondly, because the three months' period prescribed is sufficiently short to facilitate early enjoyment of rights by such workers in any case.

In regard to the applicability of the scheme to particular classes of workers, there have been numerous suggestions, but broadly speaking such suggestions fall under two groups,—those which seek to include all workers under the scheme, and those which would have only " permanent " workers. If only permanent workers are included, as soon as the term " permanent " is defined, legal loopholes are bound to be found by unscrupulous persons to escape liability under the Act. Unfortunately, in India, there are large masses of floating labour available for exploitation as casual and substitute labour in this manner. The consequence would be not only that the very purpose of the Act might be defeated but that the Fund would be left high and dry if contributions did not flow in according to initial expectation. It is, therefore, necessary to bring in all the three types of workers mentioned above in some way or other. At the same time, it is clear that the " temporary " and " casual " workers cannot be placed on the same footing as the " permanent " worker ; and some differentiation in the interests of the safety and solvency of the Fund becomes necessary.

The definitions given above partly follow precedents suggested by certain Standing Orders prevalent in some of the Provinces. However, at present, there are no reliable records of service available to decide this question. It is, therefore, necessary that the Fund should have its own records. For this, the employers will be required to maintain Service Cards, in which there will be entries of employment, re-employment, leave, resignation, dismissal, wages, etc. The employer will be required to notify the Fund regarding the occurrence of any such event within the prescribed dates. It will be seen that any worker can qualify himself for any of the three types mentioned in the text, as soon as he has fulfilled the necessary conditions. Thus a worker may be " casual " to-day, but " temporary " or " permanent " later on, as the case may be. Similarly a " temporary " worker may become " permanent " if at any time he works for 3 months in a continuous manner. Needless to say, the counting of the period will commence from the date on which the Act comes into force, or on the date of first employment, if this is later.

If a " permanent " worker remains unemployed for a continuous period of 12 months or more, he will lose his " permanent " status ; and if a " temporary " worker remains unemployed for a period of 6 months or more, he will lose his " temporary " status. This sort of provision is necessary to safeguard the Fund from possible liability for medical benefit in the case of workers who are unemployed for long periods but may be getting work in insurable industries just for a few days in the year. In the absence of the provision it would be possible for such a worker to qualify himself for medical benefit with even a week's work. The problem, however, is not likely to arise in the case of " casual " workers (*vide* Chapter IV, Section D).

The importance of this classification (permanent, temporary and casual) will become clear later on. The employer will contribute in respect of all these three types of workers ; but only " permanent " and " temporary " workers will make their contributions, while the " casual " worker will pay nothing. Similarly, only " permanent " and " temporary " workers will get cash and medical benefits, while the " casual " workers will get only some medical benefit until they qualify themselves for full benefits by becoming either " permanent " or " temporary " workers.

As the question of " permanency " or otherwise of a worker will not be decided till the third month is completed, naturally, he cannot be asked to pay his part of the contribution. For this reason, the casual worker will pay nothing. Until the status of the worker is decided, however, the employer will have to pay his contribution in respect of all the three types of workers. In the final analysis, this means that the employer alone pays the contribution in respect of the " casual " worker, because till the end of three months' service, all workers are " casual." In all countries where sickness insurance is in force, the rule has been that the contributions begin as soon as (a) the Act comes into force in relation to an industry in which the insurable worker is employed, or (b) as soon as the worker joins an industry where such an Act is already in force. In India, however, such immediate application is not possible in the case of workers, because their status is yet to be determined ; but such is not the case with the employers who are in a position to pay right from the beginning. Moreover, this requirement is consistent with the rule suggested, that the employer alone pays for the " casual " worker.

E.—Classes of Workers (Included and Excluded)

All " workers " as defined under the Factories Act, and working in insurable industries will be covered, subject to certain special cases mentioned hereafter. This means that apprentices will also be included.

Whether a worker belongs to an insurable occupation or not is a matter to be decided first. If he does so, he is *ipso facto* and, as on the date of first employment or on the date of the promulgation of the Act, whichever is later, liable to be insured. This means that both he and his employer will be liable to make their respective contributions in the prescribed manner. His insurable status, moreover, will remain until he is dead or over 60 years old. During the currency of such a status, however, owing to various causes the right of the worker to insurance may be suspended, either in respect of contributions or in respect of benefits or both, but such occasions will not completely destroy the worker's insurable status. Thus, for example, supposing a worker after having insured for some time and put in the necessary " qualifying period " (*vide* Chapter IV), becomes unemployed, for a prolonged period, the question will arise as to his rights. In this case the answer will be that (a) the worker's contributions will cease as soon as he becomes unemployed, and (b) his benefits will continue for the duration of a " protective period " which is implicit in the provisions relating to cash and medical benefits (*vide* Chapter IV, Sec. C-b and Sec. D).

It is not possible to accept at this stage the suggestion that the unemployed worker should be allowed to contribute and keep his right to benefits alive for a longer period than the protective period permits. In the first place, there will be the difficulty about the employer's contribution. Even if the worker volunteers to pay this, it is doubtful if he can go on doing so for long in view of his unemployed condition. Secondly, there is the even greater difficulty of collecting the contributions. The employer will be the usual agency for this, but even if it is suggested that the worker might be allowed to pay directly to the Fund's office, there is no guarantee that the worker would stick to the locality for long ; he might go to his village and then there would be little continuity in payments. By and large, therefore, there is no doubt that to allow unemployed workers to contribute will introduce complications in administration and accounts. Finally, so long as a full-fledged scheme of unemployment insurance is not developed for the workers, there is every likelihood of the health insurance scheme being saddled with the responsibility of supporting the unemployed, for malingering is likely to prevail to a far greater extent here. This facility should therefore, be on the future agenda of health insurance.

In the light of these considerations and also of recommendations in Chapters III and IV, *infra*, let us consider the position of various kinds of workers :—

(i) *Principally industrial but subsidiarily agricultural workers,* will be covered in such a way that when the worker goes to his village for agricultural operations, he would be treated as " unemployed " for the purposes of the scheme. The same applies to seasonally industrial workers.

(ii) *The " badli " or substitute worker* will be covered to the extent that he fulfils conditions regarding qualifying period, service, etc.

(iii) *The unemployed worker* will not be covered, but for certain " protective periods " his benefits will continue. Such a worker will obviously not contribute.

(iv) *During sickness* a worker will not contribute but will receive benefits according to the rules.

(v) If a worker is *absent on leave with pay,* he will be regarded as employed and will both make contributions and receive benefits. But if he is *on leave without pay* he would be treated as " unemployed ".

(vi) If a worker has *resigned,* or is *dismissed,* he will be treated as " unemployed " until he is re-employed in an insurable position.

(vii) If a worker is *transferred* from one concern to another in an insurable industry or occupation, he will still be covered and his title to insurance will be shown by his Cards which he will carry with him ; but if he is transferred from an insurable industry to a non-insurable industry, he will be treated as " unemployed " as from the date of such transfer.

(viii) Both *manual* and *non-manual* " workers " will be covered subject to other conditions being satisfied.

(ix) *During strikes and lock-outs.*—This problem will be considered in Chapter IX.

(x) *Contract Labour.*—This problem will also be considered later in Chapter IX.

In items (i) to (vii) above, whenever a situation arises which temporarily or permanently prevents a worker from making his contribution or from receiving benefits, he is treated as " unemployed " so far as the scheme is concerned, and consequently his position regarding insurance rights will be the same as that of an unemployed worker. The problem of the absentee worker who habitually goes to his village for one thing or another is dealt with in Chapter IV, Section F, " Residential Restrictions ".

The problem of the *badli* or substitute worker has proved somewhat difficult. The *badli* worker is a preponderant element in the large mass of floating labour drawn from our landless proletariat, which is on the fringe of employment in industrial centres. He is partly the creation of the industrial system and partly an external factor imposed upon it. Whatever be his etiology, his presence constitutes a menace to labour organisation as well as to social insurance. He cannot be excluded from schemes of social insurance, because if that were done, we shall have more and more *badlis* in places like Nagpur, Ahmedabad, Madura etc., than ever before, and the whole purpose of insurance will be defeated. Nor is his economic condition such that he can be safely left out. No doubt, in some places like Bombay, " *badli* control " systems have been adopted by means of which the reliance of industry on this floating mass is minimised, both in the interests of the worker and the industry. But in other places the *badli* worker is favoured and cultivated with a view to creating a " second line of defence " in times of strikes and lockouts. Some employers, however, regard this as some

sort of charity aimed at helping the unemployed worker and plead that in the absence of unemployment relief or insurance they have to show consideration to the hundreds of work-beggars who hang about the factories. Some go still further and actually encourage the employment of *badlis* by sending out permanent workers on " compulsory leave " so as to make room for them. The percentage of *badli* workers (among all workers) may be as high as 50 per cent., but nearabout 10 per cent. in places where *badli* control operates. The inclusion of the *badli* worker is thus imperative, both for his own sake and for the sake of the stability of health insurance. The next question, therefore, is the mode of his inclusion. Here the main difficulty is that of definition. In most industrial centres, where the *badli* system prevails, the rights of the so-called permanent workers are no more precisely defined than those of the *badlis*, and, again, I have come across *badlis* who might have worked for several years without enjoying any permanent status or rights pertaining to such status. Under the present scheme, therefore, I have adopted the course of not defining a *badli* worker at all. For the purposes of the scheme, a *badli* worker may fall under any of the three categories according to the amount of service he has put in ; he may be permanent, temporary or casual. He will enjoy benefits if he has made contributions in the period previous to his sickness. It is immaterial that he may be unemployed off and on ; for the purposes of the scheme he is secured against the risks of sickness only if he has contributed and to the extent that he has contributed. As the contribution will amount to less than a day's wage per month and as the *badli* will be getting full value (on a footing of equality with other workers) for his contribution, the arrangement is not unfair to him. So far as the employer is concerned, as the *badli* worker is generally responsible for only a few days' work in the month, or in other words as more *badlis* are required to do a job than permanent workers, the arrangement will act as a deterrent and, let us hope, will lead them to adopt *badli* control systems to safeguard their own interests. All this will react favourably upon labour conditions and insurance finance, and even upon labour efficiency and industrial profits in the long run.

It will be necessary to prepare in advance a Schedule, on the British model, showing the kinds of workers who will be included or specifically excluded under each industry or occupation. This Schedule will be appended to the Act. There will also be an " omnibus clause " at the end of the Schedule stating that the Competent Authority may, on the basis of the general principles laid down in the Act itself, make further additions to the Schedule from time to time.

Whether or not a particular worker or class of workers is covered is mainly a " question of fact " and will be decided by the Competent Authority, named in the Act, in its own discretion. On a question of law, appeal may lie with the Special Court (*vide* Chapter VIII). Whether a question is a question of law or of fact is a matter which lies within the competence of the Special Court, which may give its ruling, if called upon to do so.

Special procedure will also be provided to decide any points of doubt for which no provision is made in the Act (*vide* Chapter VIII).

F.—Exemptions.

" Exemption " means exclusion by an application from the worker concerned, while *exception* means exclusion by statute or by notification and is automatic. The following exemptions may be particularly noted :—

(i) Husband or wife, sons and daughters, father and mother, and brothers and sisters of the employer.

(ii) Where any insurable worker proves that he is in receipt of an independent income of an annual value of more than Rs. 500 not arising from his personal exertions, or is ordinarily and mainly dependent on earnings derived from an occupation which is not covered by the scheme, such a worker may be exempted.

Such persons, however, must obtain certificates of exemption from the Competent Authority, which will issue them after due enquiry.

Both exemptions are *optional*. The former is supported by I. L. Convention, Art. 498 ; the latter is not a " means test " of any kind and does not imply *compulsory exclusion*, as a " means test " does in, e.g., unemployment insurance in the United Kingdom.

G.—Income Limit and Age Limits.

(1) *Income Limit.*—There will be an upper income limit of Rs. 200 p. m. The income will consist, for this purpose, of the basic salary or substantive wage, excluding allowances, bonuses, etc., as stated in Chapter III, Section A. If any worker is paid on the basis of any shorter or longer period than a month, his monthly wage will be calculated to the nearest rupee for this purpose. Detailed rules for calculation will have to be framed after the Act is passed.

If a worker, as a result of promotion, gets an income higher than Rs. 200, although he was drawing less than that before, he will cease to contribute as well as to receive benefits, subject to what has been said in Section E above, and Chapter IV, Sections C and D. For the purposes of the scheme, he will be treated in the same way as an " unemployed " worker. If, on the other hand, any person as a result of degradation, has his wage reduced from a higher level to a level below Rs. 200, he will be automatically eligible for insurance as from the date of such degradation.

The Workmen's Compensation Act lays down an upper limit of Rs. 300, but that limit is applicable to a case where compulsory liability is borne by the employer and where the costs of treating accidents or consequent damage is likely to be so serious that even highly paid workers may find it difficult to bear them. But in the case of health insurance, the average cost of sickness is comparatively low and the worker himself is a contributor. So a highly paid worker might prefer to bear the cost of sickness himself, rather than go through the formalities of health insurance. Hence the upper limit has been fixed at the lower level of Rs. 200, which, by the way, is also the limit laid down under the Payment of Wages Act, 1936. Another point to be noted is that in the present scheme only the basic wage or income is considered and not earnings as in the Workmen's Compensation Act, or the " wages " as specially defined in the Payment of Wages Act, (*vide* Chapter IV, Section A, *infra*).

(2) *Age Limits.*—The lower and upper age limits will be 12 and 60 years respectively. In view of the difficulties of obtaining correct proof of age, the worker will be required to make a declaration on oath and in writing, which must be witnessed by two other persons. If a birth certificate is available, no such declaration would be necessary. It will always be open to the Fund to make a subsequent correction in the age entry either on its own initiative or on the worker's application, on the basis of independent proof. There will be a provision in the Act that any person found to have wilfully and knowingly understated his age will be liable to prosecution.

It has been suggested to me that there should be no upper age limit, so long as persons above 60 are being employed, and that such persons should not be deprived of benefits available under the scheme. The fixing of age limits is in conformity with the I. L. Convention (Art. 498-1-e) and, from the actuarial standpoint, it is a very essential feature of any scheme. As experience of foreign countries shows (*vide* Appendix XIII) the incidence of sickness among

the older strata of the working-class population is much higher than in the younger ones. The Indian statistics in this regard (*vide* Appendix VI) no doubt do not corroborate this universal tendency, but I am not sure that this is due to better health among old workers in India than elsewhere. Especially when cash benefit becomes available, I am afraid the morbidity experience is likely to shoot up particularly in this region as the *malade imaginaire* predominates just here. To meet the higher incidence of sickness among old workers, it is additionally suggested that the employer should be made to pay a higher rate of contribution for workers outside the age-limits. So far as the lower limit is concerned, this question does not of course arise, as that limit is fixed by the Factories Act already. If, however, employers are called upon to pay a higher contribution in the case of old workers above 60, will it not be a deterrent to the employment of such workers ? The proper course to deal with the problem is to provide for Old Age Pensions for such workers and if possible compulsorily retire them after 60 or, say, 55. In any case, in conformity with the principle stated by me in Chapter I, Section G, 8, I do not think that the present scheme of health insurance should be burdened with a liability which must be borne by a separate scheme altogether (*vide* Chapter I, Section F, Assumption B). With the institution of Old Age Pensions, there will be an automatic upper limit, and if this is lower than 60, the upper limit of health insurance may also be correspondingly reduced. In view of the much lower expectation of life in India, not only Old Age Pensions will be cheaper here to manage, but a lower limit than 60 (say, 55) may be feasible.

The fixation of an upper age limit, however, does not prevent the employers from engaging men older than 60. It is, therefore, necessary that the employer should be required to pay his contribution irrespective of any age limit in respect of all workers employed by him, so that there should be no preference on his part for employing persons outside the age limits. Of course, the worker himself will make no contribution here.

H.—The Position of Foreign Workers.

The scheme should be made applicable to the entire labour force in the industries selected, irrespective of nationality or race. But complete equality between indigenous and foreign workers should be subject to the possibility of retaliation in appropriate cases. The powers of reciprocity and retaliation should be reserved to the Government of India. If the Government of any foreign country discriminate against Indian labour in this or other respects, the Government of India may place the labour of the offending country employed in India under special handicaps, until such discrimination is withdrawn in the foreign country. The Government of India should be free to decide whether and to what extent this power is to be used in particular cases. Special conditions may be laid down in the case of foreign workers living temporarily in India. For securing equality of treatment, moreover, it would be convenient to enter into reciprocity arrangements with foreign countries, somewhat along the lines of the British Health Insurance Act, 1938, Sections 66-7. If a foreign worker is excluded from the scheme on any grounds, the employer should be required to pay his contribution in respect of that worker notwithstanding such exclusion, lest preference is shown for employing foreign labour.

Chapter III.

CONTRIBUTIONS.

A.—The Basic Principles.

The basic principles adopted here will be as follows :—

(1) Whatever be the type of worker, whether " permanent ", " temporary " or " casual " the employer's contribution in respect of him will be the same.

This will not only simplify accounts but also leave no incentive to the employer to mis-state the wage-categories of workers. (See below).

(2) There will be no non-contributory class, but for simplicity's sake, only three wage-groups will be created, *viz.*, workers whose daily wage is Re. 1 or more, those whose daily wage is As. 8 or more than As. 8 but less than Re. 1, and those whose wage is less than As. 8. Differential worker's contributions are suggested for these three wage-groups, in such a way that the low-paid worker will have to pay less than others.

(3) For purposes of Health Insurance, only the "substantive" or "basic" wage, excluding all bonuses, allowances, etc., will be taken into consideration, in view of the fact that such bonuses and allowances are in many cases a temporary and fluctuating affair and hence are likely to complicate accounts, budgets and the day-to-day administration of the scheme. If, however, in any particular case, it can be proved that an allowance is so fixed as to be almost a part and parcel of the basic wage, the authorities may decide to include such an allowance in the basic wage for this purpose. As regards piece-wages, the basic wage of a worker will be calculated on the basis of his average monthly earnings during the twelve months prior to his entry, after deducting therefrom all allowances and bonuses, provided that if a worker is employed for less than twelve months, the average will be calculated by reference to the actual number of completed months, or, if less than a month, by reference to the actual number of days.

The term "wages" has been defined in the Payment of Wages Act as including the basic wage as well as other monetary payments like bonuses and allowances (except contributions to Provident Funds) made to the worker. If we accept this definition, we would have the advantage that the term would not have to be defined anew and our definition would not clash with existing practice. But it would have the disadvantage, both for the Fund and for workers and employers, that there would be a large class of workers on the margins of the wage-groups constantly moving to and fro between adjacent wage-groups according to frequent changes in allowances and bonuses.

B.—Contributions.

(a) *Period of Contributions.*—A monthly contribution is payable by the employer for every calendar month during the whole or any part of which the worker has been employed, but not more than one contribution is payable for any month in respect of the same person and no contribution is payable by the employer for any calendar month during which no services have been rendered and the worker (a) has received no remuneration, or (b) has been in receipt of sickness benefit for the whole or any part of the month.

There will be a similar provision for the workers' contribution.

The term "employer" will have to be clearly defined. The question appears to be still under consideration (*vide Proceedings of the Third Conference of Labour Ministers*, pp. 89 ff). In my opinion, so far as Health Insurance is concerned, the term should be synonymous with the term "occupier" as defined in the Factories Act, 1934, Sec. 2, Cl. (1). As regards "contract" labour, following the British model (*vide Collection of Contributions Regulations*, 1938, Part VI, Sec. 34), we might hold the "principal employer" (occupier) responsible for payment of contributions in respect of labour employed by an "intermediate employer" (contractor). (See Chapter IX also).

The above provision regarding the period of contribution has been adapted from a similar provision in the British Act. It is necessary because any other system of contributions to suit the case of casual and temporary workers is

bound to give rise to serious complications in accounting and administration. Actually, the provision will impose a slight premium on the cost of employing temporary and casual workers. It will have a similar effect of differentiating in favour of a worker who is prepared to stick to his job, while the worker who works sporadically will be correspondingly penalised. It must be stated, however, that this provision is absolutely essential from the viewpoint of the solvency of the Fund. Its other effects, such as discouragement of excessive labour turnover, will also be proportionately useful. I think it will also popularise " *badli* control " systems with employers.

It may happen that though the whole period of service is less than a complete month (e.g., from the middle of one month to the first week of the next month), two contributions may be payable by both employer and worker in respect of the worker so employed, because the employment has been for a part of each of the two calendar months.

I have given the most careful consideration to the suggestion that the week, instead of the month, should be the period for contribution. Unfortunately, at present there is no uniformity in the lengths of wage-periods in India. Under the Payment of Wages Act, no wage-period must exceed a month, and the most common practice is payment by the month, but in certain areas there are considerable variations, and wages are paid daily, weekly, *hafta*-wise (where the *hafta* can be anything between 12 and 16 days), and monthly. The period varies both by locality and industry. In the jute mills of Bengal, barring clerks, artisans and menials, who are paid by the month, all textile workers are paid by the week. In the cotton textile industry of Bombay, Cawnpore and Nagpur, the month is the general rule. But in Ahmedabad, the period is a *hafta*, a nondescript affair. In the engineering industry, payment is generally by the month, but weekly payments predominate in Bihar and fortnightly ones in Assam, Bombay, Delhi and Madras. In the mining group, weekly payments are more common than monthly ones, except for skilled labour. In the transport services, payment is by the month. Likewise, in the minor industries, practice of wage payment varies widely.

The suggestion that we should have the month as the basis of contributions does not imply any opinion about the desirability or otherwise of adopting a uniform weekly wage-period throughout the country. So long as the wage-period is not regularised one way or the other, we have to choose the basic period according to the existing convenience. From the viewpoint of the Fund, there are at least three distinct advantages in adopting the monthly basis : (i) there will be less book-keeping and less administrative costs ; (ii) there will be less use of paper for registers and cards of all kinds ; and (iii) there will also be economies in the use of stamps. From the viewpoint of employers, there are certain vital advantages : (i) firstly, the book-keeping as well as cost of administration would be less here than under other periods ; (ii) secondly, the chances of default would be less as fewer occasions for affixing stamps would present themselves ; (iii) thirdly, as a majority of workers are governed by the monthly basis, this will conduce to the convenience of a greater number of employers. As regards employers following other wage-periods, there is not much inconvenience either, because all that they have to do is to make the deduction from the first week's or fortnight's wage in the following month, while if a worker is dismissed or resigns earlier, the contribution will be paid earlier in either eventuality. On the other hand, the shorter periods will mean more staff and higher costs to employers all round. Workers receiving payment on the basis of the longer wage-periods might easily misunderstand the collection of five weekly contributions in some months and four in others. It may, however, be contended that in respect of *badli* or contract labour, the employer

(who pays on the weekly basis) may have to pay more by way of contributions. I am not convinced that, on the whole, even in regard to this type of labour there will be any disadvantages. In the first place, the *badli* or contract worker may be employed in the same month again in the succeeding weeks, for which contributions may have to be paid. Secondly, the cost of greater book-keeping and administration to all concerned may be quite substantial. Thirdly, the *badli* worker's own chances of employment on a permanent basis will increase considerably owing to the fact that the employer's contribution in respect of him has already been paid under the monthly basis.

(b) *Time of Contribution.*—On the first day for which the worker has been employed during a calendar month, employer and worker will both be liable for payment of their respective contributions. Liability to pay does not necessarily mean that either the payment of contributions or the deduction is to be made on the first day. As the employer is charged with the responsibility of collection of both the contributions, this means that the employer *ipso facto* becomes a debtor to the Fund on the very first day of the worker's employment during a calendar month. The joint contribution must be "paid" by the employer to the Fund in the prescribed manner (i.e., by stamping), within seven days of the date on which this liability arises.

As the worker may be paid on a daily basis, and may have employment at any time during the month, it will be most convenient to deduct his contribution from the first day's wage. In practice, the employer shall effect the deduction from the wages payable on the first pay-day immediately following employment. In any case from the point of view of the Fund, the contribution must be regarded as a "first charge" on remuneration to be paid in respect of the first day of actual employment in the month.

The normal time for stamping cards will be when wages are paid. If wages are paid weekly, the card shall be stamped at the time of the first weekly payment in the month. If, also, wages are paid fortnightly, the card shall be stamped at the time of the first fortnightly payment in the month. If, however, wages are paid daily the card shall be stamped at the time of the first daily payment in the month. Stamping in advance will be permitted in the following cases : (a) when the employment terminates, the card must be stamped up to date ; (b) also when the employer has given 48 hours' notice and demands the card to be stamped up to date. An employer may, if he chooses, always pay contributions in advance ; but he cannot recover their value if the worker should leave and enter other employment before the contributions fall due.

(c) *The Structure of Contributions.*—There will be three classes of workers according to the daily basic wage : Class A, consisting of workers whose daily wage is Re. 1 or more ; Class B, consisting of workers whose daily wage is As. 8 or more but less than Re. 1 ; and Class C, consisting of workers whose daily wage is less than As. 8.

There will be no differentiation according to sex or age.

The respective rates of monthly contributions for employer and worker are shown in the table below :—

	Class A.	Class B.	Class C.
	Rs. A. P.	Rs. A. P.	Rs. A. P.
Employer's contribution*	1 4 0	1 4 0	1 4 0
Worker's contribution*	0 12 0	0 8 0	0 4 0
Total ..	2 0 0	1 12 0	1 8 0

* *See* also Chapter IX, Section A.

Where payment is on an hourly basis, the number of hours which constitute the standard day will be decided by the Local Committee, set up under the Insurance Act (*vide* Chapter VI), after taking into consideration conditions in the industry and local practice.

There may not be much difficulty about time wages, but where payment is on a piece basis, the calculation of the basic daily wage rate for different classes of workers will be determined by the Local Committees along the lines suggested in the Factories Act, Sec. 47, sub-sec. (3). This sub-section authorises Provincial Governments to fix time rates equivalent to piece-rates in consultation with the industry concerned for the purposes of determining extra pay for overtime. I made enquiries to find out how far suitable material already existed in the Provinces for the purpose of thus determining the overtime pay. Governments of Sind, Madras, Assam, Delhi and Ajmer-Merwara, Bengal, U. P., C. P. and Berar, Bihar and Orissa replied. It appears that, although in some Provinces registers have been prescribed, no necessity has arisen for maintaining registers or calculating time-rates, either because factories were working on time-rate basis, or because although piece-rates were prevalent in some factories, there was no overtime worked in them. In any case, whatever might have been the practical application of Section 47 in this regard, there is no doubt that the method is sound and that, if rightly pursued, it can yield reliable results. And, moreover, I cannot think of any alternative device for dealing with piece wages.

Where payment is on a weekly, fortnightly (including *hafta*) or monthly basis, appropriate rules might be laid down for calculation of the daily basic wage, e.g., by dividing the total wage by the actual number of days worked, whether six, seven, twelve, twenty-six, etc. This again, is obviously a matter for the Local Committees, who should take into consideration local variations in practice.

The level of contribution rates for employer and worker has been determined after taking into consideration various conflicting points, including the ability of the two parties to pay, the cost of the scheme, and previous suggestions in this regard. For instance, Sir (then Mr.) F. Stones, one of the representatives of the Millowners' Association, Bombay, had suggested a total monthly contribution of Rs. 1-8-0, Re. 1 being paid by the employer and As. 8 by the worker, in his evidence before the Bombay Textile Labour Enquiry Committee (*Report*, p. 327). The Bombay Committee themselves suggested an employer's contribution of As. 10 and a worker's contribution of As. 5 (in the case of female worker As. 4), Anna 1 being payable by the Provincial Government. In the present scheme, a flat contribution of Rs. 1-4-0 is suggested for the employer and a variable one of As. 12, As. 8 and As. 4 respectively for the three classes of workers. It may be noticed that there is no non-contributory class set up here. Where a system of non-contributory class exists (as in Great Britain, Norway, Japan, Esthonia, Latvia, etc.), the employer is required to pay his own contribution as well as that of the worker. By comparison, therefore, the present scheme is not unfavourable to the employer in India. It may be recalled that at a joint meeting of representatives of the Employers' Federation of India and the All India Organisation of Industrial Employers, at Calcutta, on 2nd January 1942 (*vide Proceedings of the Third Conference of Labour Ministers*, p. 53), a view was expressed that employers would prefer to pay higher wages so as to enable workers to make some contribution. This cannot be regarded as mere philanthropy or foolish accountancy, but as correct realisation of the principle that the worker should feel that he has a stake in the insurance fund which is built up partly with his own contributions.

That brings us to the question of the cost of contributions to the industry. It has been already pointed out earlier in Chapter I that this can be no valid

objection to the introduction of a highly desirable measure like health insurance. The magnitude of the cost as a percentage of the final costs of industry is of the second order of smalls ; for, the contribution is a small percentage of the monthly earnings of the worker, and wage costs themselves are part of the total or final costs. The increase in efficiency, as a result of the improvement in health and attendance, must also be set on the other side of the account. Mr. Lloyd George, the father of British health insurance, made some enquiries from German employers as to their experience as to efficiency and other factors consequent upon the introduction of " the first great scientific experiment in insurance on a national scale " (in Germany) and their replies were very encouraging. This is what Mr. Lloyd George said :—

" And a superb scheme it is. It has saved an incalculable amount of human misery to hundreds of thousands and possibly millions of people who never deserved it. Wherever I went in Germany.....men of all ranks, sections and creeds joined in lauding the benefits which have been conferred upon Germany by this beneficent policy. Several wanted extensions, but there was not one who wanted to go back. The employers admitted that at first they did not quite like the new burdens it cast upon them, but they now fully realised the advantages which even they derived from the expenditure, for it had raised the standard of the workmen throughout Germany. By removing that element of anxiety and worry from their lives it had improved their efficiency." (*Vide, The People's Insurance,* pp. 10-11).

What has happened elsewhere must surely happen in India, where the margin for improvement in health and efficiency is so great.

In the present scheme, the " flate-rate " principle has been adopted both for contributions and (as will be seen from Chapter IV) for benefits. There is no doubt about the actuarial convenience and simplicity of this procedure. Sir Alfred Watson, the first Government Actuary in the United Kingdom, who had to sponsor the actuarial side of British health insurance stated (vide *Transactions of the Eighth International Congress Proceedings,* Vol. 5, p. 215) as follows in this connection : " The earnings of industrial workers not only vary as between different trades and industries, but also fluctuate in the case of individuals with changes in the economic conditions. It has seemed to us in Great Britain peculiarly difficult to equate contributions to the benefits on an actuarial basis where both are liable to vary with conditions that cannot be predicted..... In Great Britain, it has been considered necessary to justify the contributions proposed to be charged, by reference to actuarial conditions, and the criterion selected has been the relation of the rate to the value of the benefits granted to young persons entering into insurance at the age of 16. Proposals that contributions and benefits should vary with earnings were not lacking when the health insurance scheme was under consideration, but the adoption of uniformity in these respects made it possible to proceed on a strictly actuarial basis, a result that had no small effect on the fortunes of the scheme when it was presented to Parliament." Sir William Beveridge too favours the flat rate basis as against the percentage or proportionate basis. He makes it one of the six fundamental principles of his social insurance scheme, the other ones being flat rate of subsistence benefit, unification of administrative responsibility, adequacy of benefit ; comprehensiveness, and classification. (See his *Report,* p. 121). Sir Walter Kinnear, one of the greatest authorities on health insurance, observes (*Report on Health and Pensions Insurance*—Australia, p. 10) : " The sickness and disablement benefits payable in Great Britain are on a flat rate basis. They do not vary according to the weekly earnings of the insured persons and, in this respect, the British scheme differs from the schemes in most other countries. A flat rate of benefit has enabled a flat rate of contributions to be charged, and Great Britain has therefore

been able to avoid the expense, complexities, and consequent worry to employers which are entailed by a scheme of contributions which vary according to the rate of the weekly earnings."

In relation to Indian conditions, it was the considered view of Mr. J. H. Thomas (late Superintendent of Insurance) that differential rates of contributions and benefits should be avoided as far as possible. " Not only do they introduce great complications into the administration but they also affect the financial basis in the sense that they require the introduction of undesirable assumptions into the mathematical calculations underlying the scheme. It is submitted that the difficulties of starting a scheme in India are in themselves so great that it is undesirable that this complication should be introduced at the outset..... " (Mr. Thomas's Note submitted to the Second Conference of Labour Ministers,—*Proceedings,* p. 68). The Bombay Textile Labour Enquiry Committee were also of the same view (*vide* their *Report,* p. 325). The suggestion that contribution rates (and benefit rates) should be related to wages or earnings as a percentage or on a sliding basis cannot be accepted for various reasons. In the first place, apart from the great divergence of wage rates as between industries, centres and occupations, the various questions of time and piece rates and fluctuations in those rates are bound to arise. Secondly there will be complications in accounts and in actuarial calculations. Thirdly, according to variation in his wages or earnings, the worker (and his employer) will have to go on paying contributions at constantly varying rates.

The flat-rate principle, however, is modified slightly along lines of the British plan of health insurance under which there have been broadly three categories of workers according to wages earned, those earning 3*s.* or less per day, those earning over 3*s.* but not more than 4*s.*, and those earning more than 4*s.* Too many wage classes, as in Japan, Austria, Poland, and some other countries, border on the percentage basis and must be avoided, as in the absence of wage statistics, the percentage basis would not only complicate the affairs of the Fund in every way but also make any actuarial forecast impossible. The main purpose, *viz.*, payment according to ability will, however, be served by the three-fold classification of the workers suggested above, as rough justice will be available under it.

Another important point to be noted is that the employer will be required to contribute the same flat rate of Rs. 1-4-0 in respect of all types of workers, whether they are " permanent ", " temporary " or " casual ". On the workers' side, only " permanent " and " temporary " workers will contribute. The " casual " worker will pay nothing. This means that the employer will deduct contributions from the wages of the first two classes of workers only and not from those of the third. But as soon as a " casual " worker becomes " permanent " or " temporary ", he will be liable to pay.

It is a highly essential part of the scheme that the employer must be left with no incentive to differentiate between the three types of workers, but that his contribution must be the same for each. Any other system will involve evasion and consequent financial difficulties for the Fund.

For the sake of simplicity and also owing to lack of data regarding sickness no differentiation according to sex or age of workers has been made in regard to the contributions that are payable. Also it is presumed that the low wage-earning capacity of women and children is already provided for in the dichotomy into wage-classes suggested above.

It may sometimes happen that the wage of a worker is reduced or he is degraded either because he commits some offence or because he proves

incompetent. In such a case, the worker would have to contribute according to his " status " at the time the contribution fell due. He would be entitled to the scale of benefit appropriate to the contribution last made by him. Conversely, there might be an improvement in the worker's grade during the course of the calendar month. In such a case, again, he would make the contribution according to his status at the time the contribution fell due, and he would be entitled to the benefit appropriate to the contribution last made by him. The financial consequences of the above proposal would be that the additional cost under the former contingency would be cancelled out by the reduction on account of the latter.

C.—Agency for Collecting Contributions.

The employer would be required to collect the contributions. He will pay his own and the worker's contributions to the Fund in the prescribed manner (see below) and recover the worker's contribution by deducting it from his wage at the time of payment of wages. There will be a suitable modification of the Payment of Wages Act, Sec. 7, Sub-section 2 to permit such a deduction.

D.—Method of Collecting Contributions.

Contributions will be collected according to the Stamped Card System prevalent in Great Britain and some other countries. Full details of this System are given at a later stage. (*Vide* Appendix XIV.) For the present, the following salient features may be noted :—

(1) The Contribution Card will contain the worker's name, signature or thumb impression, address, name of centre, date of joining the Fund, date of withdrawal, etc.

(2) The employer will be charged with the duty of stamping the Card and may retain it for stamping purposes with the consent of the worker until expiration of its currency. On certain occasions, such as termination of employment, expiration of the currency of the Card, or on request by the insured person for his Card, the employer may surrender the Contribution Card to the worker against a receipt.

(3) The employer will purchase stamps from the Office of the Centre in which his factory is located. Every month he will affix a stamp equal in value to his own and the worker's contributions.

(4) The normal time for stamping Cards will be up to the seventh day from the first day of employment in a month, but stamping in advance in certain cases may be permitted.

(5) Where any person or persons are employed by two or more employers in a month, the first employer will be liable for contribution and stamping, but if such a worker or workers are habitually engaged by more than one employer, the employers may be permitted to enter into a registred agreement, approved by the authorities, under which payment may be made by one on behalf of all or by all in turn. The British law (*vide* Collection of Contributions Regulations 1938, Part V) provides for such agreements and the provisions in this regard can suitably be adopted here.

(6) If the worker is employed by two or more employers during the month the first employer will be liable for contribution and stamping, but if such a worker is habitually engaged by more than one employer, the employers may enter into an agreement, which must be approved by the Competent Authority to pay the contributions in turn.

(7) In the event of a worker failing to produce his Card when required by the employer, the latter must obtain a special Emergency Card for him which would contain only one monthly entry. Such Emergency Cards would be available at the Fund's Offices.

(8) In certain cases the employer will be required to surrender the Card to the worker on demand ; and similarly, to the Fund's Office on demand.

(9) The Offices of the Centres and Sub-Centres will act like post offices in regard to the collection of contributions and payment of cash benefits. They will sell stamps to employers within their respective jurisdictions and keep detailed accounts of the sale of such stamps to them.

(10) If an employer fails to pay in time, workers will not be penalized for his neglect. They would be entitled to all privileges as if their contributions had been duly paid.

E.—Specimens of Cards.

Specimens of Contribution Cards and other cards have been obtained from the Ministry of Health (of His Majesty's Government). These will be found useful in evolving our own stamped card system, as also in preparing forms of Contributions and Benefits Registers to be maintained at each Centre and Sub-Centre. Some of the cards are reproduced in Appendix XIV in an adapted form for India.

Chapter IV.

BENEFITS.

We shall now turn to the benefits available under the scheme, their extent, nature and duration, and conditions under which they will be obtained by the insured workers. The principal benefits will be two : (1) Cash Benefit, and (2) Medical Benefit. In addition, I have suggested the provision of a Maternity Benefit as an ancillary measure, the financial provision for which might be made independently. The problem of Maternity Benefit will be discussed in all its bearings in Chapter IX. The other important benefit, which like Maternity Benefit is closely linked with health insurance in other countries, is Funeral Benefit. Under the present scheme, this benefit is placed on the future agenda of health insurance. Finally, mention may be made of the Schedule of Additional Benefits given in Appendix XII. This is discussed later in Section G.

A.—The Basic Principles.

The basic principles adopted here may be briefly indicated.

(1) As far as possible, the benefits obtainable by any worker must be related to the contributions paid by him in the past. For this reason, especially in a country like India, where labour is so unstable in its character, the conditions regarding " qualifying period " must be repeated in a modified manner even after the initial stage.

(2) To prevent malingering and frivolous abuse of rights, a " waiting period " is necessary in the case of cash benefits.

(3) In the beginning, the provisions regarding cash benefits will have to be somewhat less liberal than is usually the case.

(4) Under certain circumstances, there will be " linking up " of illnesses for the purpose of calculating cash benefits.

(5) The conditions regarding medical benefits may be made more liberal than those for cash benefits.

B.—" SICKNESS."

" Sickness " may be provisionally defined as any " abnormal condition which prevents the individual from working at a remunerative occupation and entails medical treatment." This is the definition of the I.L.O. publication on the subject (M. 6, p. 73). Under the British law, cash benefit is payable for incapacity to work caused by some specific disease or bodily or mental disablement. (*Vide* N.H.I. Act, 1938, sec. 32). The Ministry of Health has found it impossible to define this term with precision and satisfaction, but, for the guidance of panel doctors, it has issued a summary of the views generally accepted by the approved societies in the payment of claims and by the tribunals in deciding appeals. According to this summary :

> It is not correct to say that it is only when a worker is either mentally and/or bodily incapable of doing a stroke of work of any kind that he is to be considered " sick." A man is to be considered " sick " when he is suffering from " some specific disease or bodily or mental disablement," and (1) if an attempt to work would be seriously prejudicial to his health ; or (2) if his condition renders him unable to follow his ordinary occupation, and it is probable that he will soon be able to resume that occupation, so that it would be unreasonable to expect him to undertake any other form of work in the meantime. In cases of doubt, reference must be made by the medical officer to the Regional Board. (Harris and Sach, *Medical Insurance Practice,* pp. 114-5).

It is obvious that detailed rules along these lines will have to be prescribed in the light of foreign experience and I think we can draw particularly upon Henry Lesser's classical commentary on the National Health Insurance Act (pp. 69 ff.) in this connection. It should be noted that (1) " sickness " here is not the same thing as in medical science ; and that (2) cash benefit is available for " sickness " only, while medical benefit would be available for " sickness " as well as other illnesses and ailments. Under the British law of workmen's compensation, distinction is drawn between " total " incapacity and " partial " incapacity ; and this distinction is followed in the Indian Act also. Two separate types of injury are thus provided for in assessing compensation,—injuries specified in Schedule 1 and injuries which cause permanent partial disablement but which are not specified in that Schedule. No such distinction is drawn here. The essential point to prove is that the applicant for benefit is suffering from a specific disease or bodily or mental disablement of such a nature and to such a degree that he is unable to do any work which is reasonably open to him.

Under the present scheme, certain types of sickness will be excluded for the purpose of cash benefit but not for that of medical benefit :—

(1) Certain chronic diseases of an infectious character, such as tuberculosis, leprosy, venereal diseases, etc.

(2) If the sickness is the direct result of drunkenness or of culpable participation in a brawl.

(3) If the sickness is self-inflicted.

(4) If it is attributable to the misconduct of the insured person (the term " misconduct " including poisoning, foolhardiness or wilful mutilation).

In the case of excluded chronic diseases like tuberculosis, leprosy, venereal diseases, etc., which will be scheduled under the Act, only dispensary treatment can probably be given in the beginning. When funds permit, it may be possible to have special hospitals and clinics for such diseases. Moreover, this being eminently a field in which Departments of Public Health can and should function, workers suffering from these diseases could be sent for segregated treatment in public institutions, wherever they exist (or arise in future). It

will be impossible to pay cash benefit for these diseases. For one thing, unfortunately, a very large percentage of workers are known to suffer from these diseases ; for another, the dividing line between incapacity and capacity to work is very indistinct here. This will lead to laxity in certification.

C.—Cash Benefit.

Cash benefit is a vital part of a scheme of health insurance. A sick man does not get well by drugs alone ; the fact that food and shelter are available for him and the peace of mind that comes from knowledge that his family have their maintenance secured are important elements in his recovery. Cash benefit, in this sense, can be regarded as a vital part of treatment itself. There is thus a close interrelation between the two benefits, which manifests itself also in the converse direction ; for, just as provision of cash benefit is necessary to reduce the incidence and duration of sickness, medical benefit is necessary to reduce it as well and thus minimise the liability of the Fund in regard to cash benefit.

In determining the structure of cash benefit, I have kept in view three important principles, which conduce to simplicity and administrative convenience. In the first place, as stated in Section A above, it is necessary to establish a relation not only between wages and contributions, but also between contribution rates and cash benefit rates. In the present scheme, as will be seen later, I have fixed the cash benefit rates in such a way that the worker during sickness will get *per day* exactly what he has contributed *per month*. This simplifies matters, for the worker will know precisely how much he is to receive if he falls sick. Moreover, this arrangement helps to maintain the particular standard of life to which the worker is accustomed without burdening the Fund with the responsibility of such maintenance ; for, the cash benefit rate is directly related to his contribution rate and through it to the wage rate. Secondly, I have adopted the " flat " principle in regard to payment of cash benefit as well as in regard to contributions, subject of course to the element of gradation present in the triple classification of the insured workmen. The third principle adopted by me is that of adequacy of benefit. This adequacy arises from the first principle of relationship between benefit rates, contribution rates and wage rates. It is necessary to bear in mind, however, that in deciding adequacy the rate of benefit should be, as far as possible, short of the daily earnings of the worker, so as to leave him little incentive to malinger. It will be seen that the structure of benefit rates proposed conforms to this principle, because, in the first place, the rates are 50 to 100 per cent. of the basic wages, and hence somewhat less than that in terms of the total earnings of each worker.

(*a*) *Qualifying Period.*—There will be a qualifying period of six monthly contributions, either continuous or intermittent. Until and unless an insured worker (who is not a casual worker) has put in 6 monthly contributions, he will not become entitled to any cash benefit. The question of the qualifying period will arise only in the case of permanent and temporary workers, but not in that of casual workers, for obvious reasons.

(*b*) *Duration of Cash Benefit.*—(i) A permanent worker, who has put in the qualifying period, will get a maximum of 90 days' cash benefit, provided that he has paid not less than 6 monthly contributions within the previous 12 calendar months.

(ii) A temporary worker, who has put in the qualifying period, will get a maximum of 45 days' cash benefit, provided that he has paid not less than 3 monthly contributions in the previous 6 months.

(iii) If a permanent worker fulfils the conditions applicable to the temporary worker, he will get the cash benefit appropriate to the latter. But not *vice versa*.

(iv) There will be no cash benefit for the casual worker.

The maximum duration of cash benefit has been kept at the level of 90 days (3 months) although in most countries, there is generally an equality between this and the qualifying period (of 6 months). This is only a financial precaution. From the statistical standpoint, however, a large majority of sicknesses will be of a shorter duration than even 90 days. Although cash benefit will be available up to 90 days only, there is no limit generally to the duration of the medical benefit (see *infra*). If funds permit, later on, the duration of the cash benefit can be extended.

The significance of the differentiation between the permanent and temporary worker here is that, in all probability, the permanent worker has been paying contributions regularly not only in the previous 12 months but also in previous years, but the temporary worker cannot be expected to have done so, as otherwise he would not remain temporary for long. Thus the cash benefit is related to the contributions *probably* paid, and on the average the parallelism is likely to be considerable. *These provisions have been necessitated by the peculiarly migratory character of Indian labour and are a highly essential part of the Scheme.* It is this that has also necessitated the sub-division of the insured working-class population into "permanent", "temporary" and "casual" workers. See *ante*, Chapter II.

(*c*) *Waiting Period.*—There will be a waiting period of three days. Only if sickness exceeds the waiting period will the cash benefit be payable and will be paid for the fourth and subsequent days of sickness. There will be no waiting period in the case of a fresh sickness, if this is "linked-up" with a previous one. (For "linking-up" of sicknesses see below.)

Almost all the national laws of health insurance lay down that an insured person cannot claim the cash benefit until after a waiting period. Claims for benefit for very short indispositions, if admitted, would mean a serious drain on the funds of health insurance, because the cost not only of cash benefits but also of administration and supervision in such cases would be high. Short illnesses, though they are not often very serious, are not uncommon and hence their admission will cost a good deal to the Fund. Moreover, where the period of indisposition is very short, it would not be difficult for the worker to maintain himself from his own earnings. From this standpoint, the device of the waiting period enables the Fund to concentrate the available cash benefit on those long illnesses which require special attention, as it is such illnesses that constitute a greater risk to the worker than short ones. This justification, however, holds good if the waiting period is not too long. The I.L.O. Convention (*vide* I.L. Code, Art. 499, sec. 2) prescribes a waiting period of not more than three days. In conformity with this, I have suggested a waiting period of 3 days. The waiting period, further, is *absolute*, i.e., even if the incapacity lasts for more than three days, the insured will get cash benefit only in respect of the fourth and subsequent days, and not with retrospective effect. Adoption of the *absolute* waiting period will not only lessen the cost but will also lead to simplicity.

An insured person will be required to give notice to the office of the centre or sub-centre within three days from the commencement of his incapacity. If the notice is not given within this time, cash benefit will not commence until the day following that on which notice is given or if the illness is treated as continuation of a previous illness, benefit will commence on the next but one day before the day on which notice was given. As an additional safeguard the Medical Officer may also be required to supply information to the office of the centre as soon as a case goes beyond the third day, i.e., on the fourth day.

This will facilitate immediate " sick visitation " also. Under the British law, benefit is payable on the fourth day even without notice, if the approved society is satisfied that a member had a reasonable excuse for not giving notice. I am not in favour of adopting this procedure, as this is likely to open up possibilities of corruption, but this is a matter for further consideration when framing the rules.

(*d*) *Scale of Cash Benefit.*—The worker will not be entitled to any cash benefit until he has paid his first six contributions. He will be entitled to only ' partial ' benefit from the time he has paid his sixth contribution and until he has paid his 24th contribution. After he has paid his 24th contribution, the worker will be entitled to full cash benefit. Once a worker becomes entitled to full benefit, he will always remain so, in spite of interruptions in his subsequent contributions due to unemployment, etc. This is in consonance with the basic principle that a worker's membership of the Fund continues intact, even though he did not contribute or receive benefits at intervals. As soon as the temporary suspension due to unemployment or any other cause disappears, the worker will begin to enjoy his full rights as if such suspension had not taken place, subject, of course, to the standing rule that 6 monthly contributions have been paid during the previous 12 months, etc.

The following table illustrates the structure of cash benefits :—

Period.	Class A.	Class B.	Class C.
Until the first 6 contributions are paid ..	*Nil*	*Nil*	*Nil*
After 6 contributions and up to the 24th contribution (Partial cash benefit) ..	0 6 0	0 4 0	0 2 0
After payment of the 24th contribution (Full cash benefit)	0 12 0	0 8 0	0 4 0

It must be made clear that the number of months in insurance put in either wholly or partly must not be less than the number of contributions paid in deciding the above as well as similar matters. For example, it will not be possible for a worker to pay several contributions in a lump sum and immediately demand benefit on the strength of such payment. It may be observed that the provision of partial benefit in the scheme will have two important advantages. In the first place, it will provide an automatic differentiation between workers who are permanent members of the scheme, and, therefore, deserving special consideration, and workers who are the flotsam and jetsam of the industry and who must not be allowed to draw upon the Fund unduly. Secondly, it will lead to the creation of a reserve which can be utilised towards strengthening the Contingencies Reserve Fund (see *infra*, Chapter V).

(*e*) *Linking-up.*—There will be linking-up of two adjacent illnesses which fulfil the other conditions laid down above. The precise Linking-up Rules will be framed at a later stage, i.e., after the Act is passed. Broadly speaking, the principle will be that if the second illness for which cash benefit is payable occurs *within one year* of the *last* day of the first illness for which also cash benefit was payable, there will be " linking-up ", and the worker will not get cash benefit for more than 90 days (or 45 days as the case may be) for the two illnesses together. Any number of such illnesses can be thus linked up.

D.—Medical Benefit.

(*a*) For this, there will be no qualifying period or waiting period.

(*b*) The insured worker—whether permanent or temporary—will be entitled to full medical benefit from the first day of illness and till he is cured of his incapacity, whether this is total or partial, subject to the provision that a

worker in respect of whom no contribution has been paid within 12 consecutive months previous to the month in which he is sick will cease to receive medical treatment from the Fund. (Cf. *Compulsory Sickness Insurance*, I.L.O. Series, M.6, pp. 285-6). But as soon as he is re-employed in an insurable industry, he will again become eligible for medical benefit.

In case the casual worker has to be included for medical treatment, it is obvious that he cannot be placed on par with the other two types of workers. Otherwise, even after working for a day a casual worker may be able to obtain medical benefit for long periods. His inclusion will also complicate medical records unnecessarily, and the need of separate registers for casual workers will arise. On the other hand, actually the number of such casual workers is likely to be very small and the Fund may not be overburdened as a consequence of their inclusion. However, from the financial point of view, it will be better if the conditions regarding contributions prior to sickness are made more strict than in the case of the other two classes. Thus, it may be suggested that, in the case of the " casual worker ", full medical benefit might be given, subject to the provision that if no contribution has been paid within the 3 consecutive months prior to the month in which he is sick, he will cease to receive medical treatment from the Fund. As soon, however, as the casual worker becomes a permanent or temporary worker, he will become entitled to full medical benefit.

It must be realised that medical benefit under the present scheme is mainly intended for the active worker, firstly, to facilitate his restoration to health and efficiency, and secondly, to serve as proof of his eligibility to cash benefit. His title to cash benefit, however, is subject to certain conditions enumerated in the previous section ; while here the medical benefit is not hedged in with too many conditions for the reason that there can be little or no malingering purely for medical benefit. Nonetheless, the Fund cannot hold itself responsible for unlimited medical benefit to workers who are unemployed for prolonged periods, or to the dependents of insured workers. The provision of medical facilities to these is obviously the responsibility of the State and that responsibility has no connection with payment of cash benefit, i.e., maintenance of the worker's standard of life. For the present, I have placed these items on the Schedule of Additional Benefits (Appendix XII), for future adoption. In view of the fact, however, that a nation-wide programme of medical services is under the consideration of Governments in India, it may be contended that the scheme would be incomplete and incoherent, if it did not provide medical benefit to workers under all circumstances as also to their dependents, and put them on par with the rest of the population. The answer to this is obvious : viz., that so long as the nation-wide programme does not come into existence, the position of excluded workers and dependents must remain the same as now and will be subject to no new handicaps. On the other hand, it may be convenient both from the viewpoint of the State and from that of the worker that temporarily excluded workers and dependents of insured workers should be catered for through the medical centres of the health insurance scheme. If and when it is decided to have such an extension of the scope of medical benefit, it may be reasonable to expect the State to subsidise that part of the extended medical benefit. In any case, the provision of this and other *additional* benefits depends entirely upon the availability of funds in the future.

Similar is the case of aged workers (beyond 60 years) who have left insurance. It is fair that a worker who has been making his contributions for a considerable part of his life, should not be left to the general medical services for treatment. This should, therefore, be an item on the future agenda. If, however, immediate provision is desired, it may be necessary to augment the funds of the scheme by a special grant from Government, for in this range, the rate of sickness is very high.

It may be noted here, in passing, that whereas workers insured with the Fund will have the right as private citizens to avail themselves of any of the medical facilities open to the general public, the converse proposition will not be true. In the first place, medical treatment here will be integrated with the payment of cash benefit, and hence if a worker wants cash benefit, he will have to be certified by a doctor of the Fund and be also subject solely to his treatment while receiving such cash benefit. Secondly, as industrial medicine will be a specialised affair to some extent, it may not be desirable to saddle the scheme with the responsibility, in any place, of catering for the general population.

It will be necessary to provide for medical attendance to the insured worker till he is cured, because a major purpose of health insurance is the cure of sick workers. Unless the worker is completely cured, he is likely to be a constant liability to the Fund. In some countries, there is a maximum limit for the duration of medical benefit. I think such a condition will be very annoying to the workers, and hence I have suggested unlimited medical benefit subject of course to one or two minor conditions, such as those relating to unemployment and " casual " status.

E.—Kinds of Medical Benefit.

The insured will be entitled to an adequate measure of properly skilled medical attendance of the average type, which general practitioners as a class can be reasonably expected to render. Special treatment (e.g., dental, optical, etc.) and hospital treatment would be provided at the discretion of the Fund only in the event of there being a surplus of receipts over expenditure, after making adequate allotment to the necessary Reserves, etc. In case, satisfactory arrangements for hospital treatment can be made with State, local-fund and private-aided hospitals, it is proposed that the worker should receive either *nil* or at the most 50 per cent. of the ordinary cash benefit. Further details are given in Chapter VII, Section E, dealing with the rights and duties of insured workers in respect of medical benefit.

F.—Residential Restrictions.

The insured worker (unless he is prepared to forgo his benefits) will not be allowed to reside outside the limits of the Centre or Sub-Centre to which he belongs, such limits being determined by the Regional Board ; but he can go from one Centre to another with the permission of the competent authority. In the event of such transfer, the medical benefit will be available on the first day on which a worker presents himself with his credentials (viz., insurance cards) which should show that he is entitled to medical benefit. This means that he can get medical benefit at any Centre, without waiting for the transfer to be sanctioned, but he will not receive any cash benefit unless the local office has received the sanction. In the meantime, a record of sickness may be required to be made by the worker if he is entitled to cash benefit.

The proposal has been made that the residential restrictions might be relaxed in suitable cases and the worker might be allowed to proceed to his village so as to facilitate early recovery. The habit of the Indian worker to return to his village on every conceivable occasion, including sickness, convalescence, marriage, death of relatives, family disputes, litigation, agricultural operations and what not, is well known. The Royal Commission on Labour (*Report*, p. 18) appropriately calls this, " homesickness." The same Commission has suggested (*ibid.*, pp. 208 ff) that the worker, insured for health, might be allowed to proceed to the village during spells of sickness, on the ground that " in some cases a return to the worker's village is likely to be of as much benefit to health

as medical attendance in the city." It might be contended that the suggestion of the Royal Commission would not only benefit the worker but even reduce the final liability of the Fund by reducing the incidence of sickness. In the first place, as the squalor of city life, its lack of housing, of ventilation, and of sanitation are responsible for the sickness, it would be a vicious circle to force the worker to remain in such squalor thereby prolonging his sickness. Secondly, by permitting the worker to go to his village, his recovery would be hastened in a positive manner and the future possibilities of repetition of sickness would also be lessened.

I have given the most careful consideration to this proposal but cannot see my way to accept it. *Prima facie,* it may appear that it should be possible to grant permission to sick workers in specific cases to proceed to the village, such permission being made dependent upon a certificate from the Fund's doctor, duly countersigned by a superior Medical Officer. Certain diseases like malaria appear to be suitable for such certification. However, whatever be the nature of the diseases for which residential restrictions have to be relaxed, it is clear that the certificate of the Fund's doctor will be the decisive factor here, because the countersigning officer is not likely to do much more than support the local doctor. Thus, the whole problem of graft and malingering will have to be faced. Once the workers realise the possibilities of getting cash benefit *in a lump sum* or periodically by this means, they will, to a greater and greater extent, take advantage of the situation and proceed to their villages, whenever any occasion demands it or even without an occasion ! The Bihar Labour Enquiry Committee (1940) conducted an investigation into the causes of village exoduses amongst working-class families in certain industrial centres. (*Vide* their *Report,* pp. 22 ff.). They found that the frequency of visits of the selected families on account of sickness was only 40 as against a total frequency of 714, in which social ceremonies accounted for 210, meeting relations for 216, religious causes 20, and economic causes 94. Sickness, thus, accounted for only 5.6 per cent. of the visits, which shows to what extent other occasions determine the worker's exoduses to the village. During sickness, again, it is worth while considering why the worker resorts to his village. He has to do this mainly because at present he gets neither wages nor medical attendance. I doubt very much, however, whether the worker would prefer to go to his village if both these conditions are adequately satisfied in the city. In any case, it will be quite impossible for the Fund to provide medical benefit to the worker in his village. This means that when sickness is in an acute form, he will have to stay in the city for proper treatment. So far as cash benefit is concerned, repatriated workers will be beyond the pale of supervision of local committees, sick visitors, employers and fellow-workers, and the certifying doctor also probably can oblige the malingerer with impunity, especially if he colludes with the countersigning officer. This might easily give rise to a "racket"!

All that can be done, therefore, is to permit the worker to transfer himself from one centre to another, if this is helpful. For the rest, the worker himself might prefer to return to his village for convalescence without insisting on any cash benefit.

G.—Additional Benefits.

Apart from the benefits suggested in the foregoing paragraphs, the Health Insurance authorities might decide to provide "additional benefits" to the insured if and when funds permit and provided the actuaries so advise. In Appendix XII, a Schedule of Additional Benefits has been given. This Schedule takes into consideration the various points at which the present tentative

scheme may appear to be halting. Moreover, in preparing it, similar schedules in foreign schemes, particularly in the British scheme, have been consulted. No order of preference has been given in the list, as the authorities, it is presumed, will be quite competent to decide which of the items should be taken up first in the circumstances then prevailing. It is neither necessary nor possible to estimate the costs of the various items in the Schedule ; nor are they of relevance to the financial or administrative arrangements to be set up now. Another point, which requires emphasis here, is that the Schedule refers only to such benefits as may be in amplification of the *existing* benefits or as may be feasible within the four corners of the present legal structure of the scheme. From this standpoint, the Schedule must be distinguished from any programme of extension of the Act with a view to inclusion of new strata of labour or new industries, or with a view to amalgamation of health insurance with other social security measures to come. Such a programme of extension will have to be financed independently, while the additional benefits under the Schedule might be financed out of surpluses of health insurance itself.

H.—Miscellaneous.

(i) No benefit of any kind, cash or medical, would be available during the first six months since the inception of the scheme. This is a period of initial safeguards and, in this respect, I suggest that we should follow the model of the British scheme, under which no benefits of any sort were payable for the first 6 months, so as to allow a fund to be accumulated out of the contributions. This will also fit in with the " time-table " suggested in Chapter IX, Section I.

(ii) Only allopathic treatment would be provided by the Fund. (See Chapter VI, Section M.)

(iii) There would be appropriate rules regarding " Behaviour during Sickness " ensuring proper treatment and speedy cure such as are in force in other countries, particularly in Great Britain, along the following lines :—

The worker in receipt of benefit under the scheme :

(a) shall obey the instructions of the doctor in attendance;

(b) shall not be absent from his place of residence for the time being between the prescribed hours, if any ;

(c) shall not leave the locality where he resides without requesting the consent of the Competent Authority ;

(d) shall not be guilty of conduct which is likely to retard his recovery ; and

(e) shall not, if in receipt of cash benefit, do any kind of work, domestic or other unless it be light work for which no remuneration is, or would ordinarily be payable, or work undertaken primarily as a definite part of the member's medical treatment in a hospital, sanatorium or other similar institution.

Chapter V.

FINANCIAL AND ACTUARIAL ASPECTS OF THE SCHEME.

In this Chapter we come to one of the central aspects of health insurance, viz., finance and actuarial balance. There are numerous questions here which merit consideration, such as the nature of the financial organisation, the actuarial system to be adopted in fixing the rates of contribution and for balancing the receipts and disbursements, the resources of the Fund apart from contributions, the constitution of emergency reserves, disposal of surpluses, account-

ing and auditing, investments, and actuarial valuations. Incidentally, I propose to examine some of the statistical material reproduced in the Appendices in regard to incidence of sickness etc. in India and abroad.

A.—Financial Organisation.

The question of financial organisation is intimately bound up with the administrative and constitutional aspects of health insurance, on the one hand, and with the actuarial aspects on the other. These various aspects will be considered later in their appropriate places. The question that needs to be answered here is : What should be the nature of the financial organisation ? Should it be (*a*) Central, (*b*) Regional or Provincial, (*c*) Industry-wise, (*d*) Centre-wise, or (*e*) Factory-wise ? The term " regional " here refers to the regions which might be set up for the administration of the scheme, while the term " centre-wise " refers to the centres or sub-centres for health insurance and medical attendance, organised in industrial areas. From the viewpoint of health insurance, there can be no doubt that the best form of financial organisation would be that in which centralisation is the key-note, providing the maximum possible " pooling of risks." A large fund is a great and effective shock-absorber and, in accordance with the principle of probability which underlies the theory of insurance, is bound to diminish risks. It would be against this fundamental principle if health insurance funds are segregated regionally, industry-wise, centre-wise or according to any other plan. The I.L.O. publication, *Compulsory Sickness Insurance* (p. 510) remarks as follows in this connection :—

" When the finances are under single control, the compensation of the risks is theoretically effected in the most favourable manner, and although systematic deviations (for instance, deviation due to epidemics) must always be taken into account, chance deviations may be considered practically eliminated. There are two other very important advantages usually connected with this form of management : firstly, much lower administrative expenses ; secondly, strong centralisation of insurance, normally allowing the constitution of large reserves. The latter, while representing a considerable margin of security, increase the scope of social insurance as regards sanitary, medical and curative and preventive institutions."

The universal trend of events is in favour of centralisation of finances. Witness, for example, the grand experiment proposed in the Beveridge Report. Even where funds were decentralised in the beginning, there is preference for consolidation. For example, in the Irish Free State, a single mutual benefit society was organised in 1933, which has taken over the assets and liabilities of all the existing approved societies. (Cf. *International Survey of Social Services*, 1933, Vol. I, p. 419). Those who argue in favour of decentralisation base their case mainly on the argument that it is unfair to subject industries or areas with a lower incidence of sickness to the same charges as those with a higher incidence. But if pressed too far this argument cuts right across the device of insurance itself, whose very essence is the pooling of good and bad risks. Speaking of unemployment insurance in a similar context, Joseph L. Cohen (in *Social Insurance Unified*, p. 57) pertinently remarks : " If a distinction is drawn between different industries, it might be asked why not distinguish between the risks of establishments in each industry ? It is not unusual for establishments in the same industry to have greater differences in their unemployment rates than exist between different industries. A stickler for consistency might even ask to have different rates of contributions applied to different departments, and even to individuals because they are less liable to unemployment."

If funds were organised according to industries, several difficulties would arise. In the first place, there would be problems of demarcation, as the scope of each industry cannot be defined quite precisely. Moreover, sickness is not distributed according to industries but mainly according to geographical areas, and if the intention is that each industry should bear its own burden of sickness, it might be found that on the average there is little difference between this and the burden arising from a common fund. The Province, again, is a bad unit for financial management, in view of the fact that in some of the Provinces industrial development has been so poor that it would be a top-heavy arrangement to have a separate Fund for a few thousand workers. Moreover, there will arise a serious lack of uniformity as regards benefits.

As stated in the beginning, the problem of financial organisation is closely related to that of the administrative machinery on the one hand and that of medical organisation on the other. It is indubitable that medical organisation itself must have a pyramidal shape, if questions of all-India medical policy are to be decided properly at an apex. Likewise, we cannot easily avoid having a central body to co-ordinate and control the pyramid of administrative machinery. It is therefore appropriate to suggest that the financial organisation should also be pyramidal in its structure, so that each part of that structure would play its own part and do its allotted task. The case for having independent funds for industries, Provinces or Regions, factories or centres, is mainly based upon the idea of adjusting premiums to risks. This idea is, however, rapidly being discarded as not being in consonance with the modern conceptions of *social* insurance. This is what Sir William Beveridge has to say about this subject :—

" When State insurance began in Britain, it was felt that compulsory insurance should be like voluntary insurance in adjusting premiums to risks. This was secured in health insurance by the system of Approved Societies. It was intended to be secured in unemployment insurance by variation of contribution rates between industries as soon as accurate valuation became possible, by encouragement of special schemes of insurance by industry, and by return of contributions to individuals who made no claims. In the still earlier institution of workmen's compensation, adjustment of premiums to industrial risks was a necessary consequence of the form in which provision for industrial accidents was made, by placing liability on employers individually and leaving them to insure voluntarily against their liability. In the thirty years since 1912, there has been an unmistakable movement of public opinion away from these original ideas that is to say, away from the principle of adjusting premiums to risks in compulsory insurance and in favour of pooling risks. This change has been most marked and most complete in regard to unemployment, where, in the general scheme, insurance by industry, in place of covering a large part of the field, has been reduced to historical exceptions ; to-day the common argument is that the volume of unemployment in an industry is not to any effective extent within its control ; that all industries depend upon one another, and that those which are fortunate in being regular should share the cost of unemployment in those which are less regular.....There is here an issue of principle and practice on which strong arguments can be advanced on each side by reasonable men. But the general tendency of public opinion seems clear. After trial of a different principle it has been found to accord best with the sentiments of the British people, that, in insurance organised by the community by use of compulsory powers, each individual should stand in on the same terms ; none should claim to pay less because he is healthier or has more regular employment. In accord with that view, the proposals of the Report mark another step forward to the development of State insurance as a new type of human institution, differing both from the former methods of preventing or alleviating distress and from voluntary insurance. The term 'social insurance' to describe this institution implies both that it is compulsory and that men stand together with their fellows." (*Report*, p. 13.).

Centralisation of funds, however, will be subject to one or two considerations. In the first place, centralisation will not rule out actuarial and statistical control according to Regions or Provinces, Industries and Centres. Such control will be necessary to safeguard the Fund from excessive or lax certification, on the one hand, and insufficient medical measures on the other, in so far as these may be responsible for a high rate of " sickness " incidence. The statistics will be the barometer showing the position of each area or industry in this respect and will point the way to reform whether in the administrative or in the medical sphere. Secondly, there will be some element of decentralisation in the actual management of the Fund, inasmuch as the system would be somewhat akin to that of Posts and Telegraphs, receipts and disbursements being arranged as far as possible locally. Thirdly, there will be Government audit and inspection of accounts at all stages.

B. Actuarial Basis.

Another important question is of the choice of the appropriate actuarial basis for the scheme. Two principal systems are available, viz., the Capitalisation (otherwise called Actuarial) System, and the Budgetary (otherwise called Assessment) System. The latter system has been in vogue in practically every country in the world, except in Great Britain and Ireland. It is simple and more suitable to the requirements of health insurance. However, this being a somewhat technical subject, I have relegated my reasons for the adoption of the budgetary system to Appendix XV, entitled " A Note on the Choice of Financial System." The system has been favoured by most of the Actuaries replying to the Actuarial Questionnaire. I am glad to state also that the Actuarial Advisory Committee have lent their valuable support to its adoption. (*Vide* their *Report*).

I shall now briefly describe the procedure which I propose to follow in regard to the Budgetary System.

(1) Statistical data relating to the incidence of sickness have been collected from various parts of the country, which, in some cases, are actually based upon existing sickness insurance schemes in operation. This indicates the probable range of the average morbidity rates for industrial labour in India. (See Appendix VI).

(2) These statistical data can be further checked and re-inforced by the morbidity experience of other countries.

(3) There are three principal factors to be taken into consideration in erecting the financial structure of the scheme on the budgetary model viz., (*a*) the structure of contributions, (*b*) the structure of benefits, and (*c*) morbidity experience. If any two of these factors are given, the third factor to the extent to which it is necessary or to which it can be supported, can be evaluated with a fair degree of accuracy.

(4) In Appendix XVI, statistical data are given to show the comparative magnitude of the expenditure on different items of costs (such as medical benefit, cash benefit, administration etc.) in different countries. It will be seen that the percentage of medical expenditure to the total expenditure varies widely, from 2.5 per cent in Sweden to 65.7 per cent in Norway (its neighbour). This is obviously due to the wide variation in the quantity and quality of medical benefit available through health insurance in different countries. If, however, we take an average, it comes to 42.2 per cent for all countries in the Table. We may adopt this figure as the probable figure in the case of the present scheme, in view of the fact that the medical benefits proposed here

are not likely to be very ambitious in the beginning. Reference may here be made to Chapter VII, Section D, wherein I have given some reasons why it is difficult to estimate the probable cost of the medical part of the scheme, and where I have also suggested the adoption of a percentage (of the total contributions) as the best line of action under the circumstances. If, therefore, we allocate a fixed maximum of 42.2, or rather 42.5 per cent of the total costs as the upper limit for medical expenditure, and further distribute this amongst the Regions on the *pro rata* basis of the number of insured workers in each Region, I think the latter can be relied upon to make suitable arrangements for the medical benefit and defray the costs out of such allocation.

(5) As regards the costs of administration, again, the same method of percentage allocation may have to be resorted to, at least in the first few years, until the scheme attains maturity. Referring to the same Appendix, it will be found that the average costs of administration in the countries enumerated in it works out at 12.1 per cent. Originally, I had made an allowance for 10 per cent only, but it was suggested by some foreign experts that this would be somewhat on the low side. I have, therefore, revised this so as to allow for 12.5 per cent of total contributions as the share going to administrative costs. this, of course, includes the administration of cash benefits and that of the various other branches, such as Actuarial and Statistical, Prapaganda, Inspection etc., but not of Medical Benefit.

(6) After making provision for Medical Benefit at 42.5 per cent, and for Administrative Costs at 12.5 per cent, the balance of 45 per cent will be available for cash benefit and for crediting of the Contingencies Reserve Fund. (See *infra.*) On the advice of the Actuarial Advisory Committee, I propose to put 5 per cent to reserves, and the balance of 40 per cent to payment of cash benefit. The Actuarial Advisory Committee have calculated that this per centage will be enough to support a claims rate of 12.4 days in the case of Class A workers, of 16.1 days in that of Class B workers and of 26.7 days in that of Class C workers. As we have no figures for the number of workers falling under each of these classes, an average figure (for the *tenable* claims rate) for all the three classes together cannot be worked out, but I should say it must be somewhere near 16 days (the middle figure of the three). In view of the fact that the maximum rate of sickness anywhere (in the statistics reproduced in Appendix VI) is 14.6 days per annum per worker, where sick pay or cash benefit was actually paid to some extent, this leaves a considerable margin of safety. I am inclined to think, however, that the actual rate of claims experience is likely to be found much lower than 16 days per annum, though the same cannot be said of the total rate of sickness. The experience of Japan is relevant here. In Japan, they started with the assumption of an average of about 11.5 days of sickness per worker per annum and gave to this a loading of 50 per cent. In actuality, the sickness rate was 70 per cent higher, i.e., about 19.5 days per annum. And yet, as a result of the rules of cash benefit, from year to year, the Fund had to pay out cash benefit only for about 6 days on the average. (See *Industrial Labour in Japan*, Chapter VI, "Social Insurance", and *International Labour Review*, 1936 and 1937, containing "Reports on Social Insurance in Japan," various years. Also, Appendix XIII, Table 40.) In view of the fact that conditions regarding cash benefit as proposed here are less liberal than those in Japan and that the data relating to sickness experience collected by me do not show that the rate of sickness is, on the average, higher than that assumed in Japan, I think the actuarial results are very satisfactory and, if anything, err on the safe side.

(7) I may state here the various *recurring* "hidden reserves", or, if we look at it from another angle, the "safety margins" which arise out of the conditions regarding cash and medical benefits proposed in this scheme.

They are briefly stated below :—

(*a*) The " waiting period " of 3 days provides the first " hidden reserve ". The average value of this depends upon the predominance or otherwise of illness of less than 3 days' duration.

(*b*) The provision of a fresh " qualifying period " of 6 months (during the previous 12 months, as suggested in Chapter IV, Section C, *ante*), which will exclude some sickness, is another safeguard.

(*c*) The provision of cash benefit for 90 days and 45 days only according to prescribed conditions, will " nibble " at sickness longer than those periods. (See Chapter IV, Section C.)

(*d*) Linking-up Rules, as broadly suggested in Chapter IV, Section C, may be expected to reduce the " payable " part of sickness still further.

(8) Another line of approach which I have pursued in this connection is to compare the relation between the total contribution and the cash benefit in this scheme with that available in regard to health insurance schemes in certain other countries. The comparison shows that under the present scheme, there will be a very large margin of safety. Thus, apart from the expenditure on other items of costs, in Great Britain the ratio between the weekly contribution and weekly benefit works out at 1 : 20 (males) and 1 : 17 (females). In India, the ratio will be between 1 : 10 (high-paid workers) and 1 : 5 (low-paid workers). In Great Britain, the cash benefits cover not only sickness for 26 weeks (6 months) but also disablement beyond that period and maternity benefit. Hence it is clear that the present scheme (which provides for a cash benefit of not more than 90 days for " sickness " only) provides enough elbow-room for a much higher rate of sickness.

(9) The above, in general, is my method of approach to the financial problem. *I do not, of course, regard the percentages suggested above as axiomatic.* In the light of further data available after the scheme has operated for some time, it would be possible to revise the distribution in a manner which would approximate better to the precise requirements of each category of expenditure. In the absence of such data, however, the method of distribution of costs is the only one that is feasible and rationally acceptable.

C. Resources of the Health Insurance Fund.

The main resources of the Health Insurance Fund will be as follows :—

1. Contributions from workers and employers.

2. Contributions, or subsidies, or other assistance from Central and Provincial Governments, if any.

3. Donations, gifts, legacies, etc.

4. Interest on investments, etc.

5. Fines and penalties.

6. Loan resources arising from the provision of " guarantee " by the Central and Provincial Governments.

7. Loans raised in the open market with the sanction of the Government of India, such loans being raised for the purposes of specific capital expenditure such as construction or acquisition of hospitals, purchase of buildings, lands and special apparatus, preventive health measures, etc., which cannot be financed out of the recurrent revenue.

8. Such other resources as may be made available to the Fund by the Government or by the public.

D. Reserves.

Under the capitalisation or actuarial system, it is necessary to build up a Reserve Fund to correspond to the " reserve values " representing the extra liability arising from the " Initial Deficit " caused by the higher sickness experience of older entrants into health insurance. Lucien Fèraud, writing in the I.L.O. Report, *Actuarial Technique and Financial Organisation of Social Insurance* (pp. 30-1) thus describes this initial liability : " The actuarial liability caluculated for the initial membership could be covered at the outset only by a large initial endowment ; as a rule, the greater part, if not all, of this actuarial liability remains uncovered and constitutes the initial liability. The contingent of insured persons entering in any particular year normally comprises a large proportion of the younger generation, and the corresponding premium would therefore be lower than the general average premium. Consequently, for this contingent taken separately, the probable present value of expectation exceeds that of liabilities, and the operation of insurance begins not with a liability, as in the case of initial membership, but with an asset." Under the budgetary system, which is adopted here, however, there is no such problem. Here each year presents a self-contained group of insured, and the assets and liabilities of the year (or, if need be, a period longer than one year) are expected to balance, more or less. Consequently, it is not necessary to build up reserves against any long-period liability here. Nevertheless, with a view to lessening the irregularity in the costs as between successive years, the budgetary system is usually amended to its advantage by the accumulation of provident reserve funds, which are used in case of need to avoid the levy of an extraordinary contribution. (*Cf.* I. L. O. publication, M. 6, pp. 434 ff. and 458 ff.) These funds are to be distinguished from the actuarial reserves under the capitalisation system, because the amounts deducted here are arbitrary, whereas an actuarial reserve must at any given time possess the appropriate value which has been mathematically calculated. The two main contingencies which are to be met here are, firstly, fluctuations from year to year in the budget of health insurance causing surpluses or deficits, and, secondly, the possibility of epidemics bringing about a sudden and steep rise in costs. Accordingly, the following two Reserve Funds are recommended :—

(1) *Contingencies Reserve Fund.* (a) This reserve will be necessary to meet any *sudden and excessive rise* in the " claims experience " which is a usual occurrence in the first few years of the life of the Fund. (b) It will also meet any *ordinary fluctuations in the claims* during normal years. (c) Similarly, it is clear that during *periods of* depression, the rate of sickness may go up while employment, i.e., contributions) may fall off.

(2) *Epidemic Reserve Fund.* It is clear that the Fund cannot bear the strain of epidemics in particular areas, cholera, small-pox, etc., which are prevalent in a localized manner in particular areas during ordinary times ; nor of epidemics which have a nation-wide sweep, such as influenza (*e.g.*, of 1918), plague, etc.

As regards the Contingencies Reserve Fund, the following main sources are likely to be available :—

(i) A small percentage deduction from the total contribution. (See Section B *ante*.) This will be 5 per cent. of the total contributions collected.

(ii) Annual surpluses of the budget of health insurance, if any.

(iii) Fines and penalties imposed upon workers and employers for breaches of the Health Insurance Act.

(iv) Interest on the Contingencies Reserve Fund and profits of investments, as also interest payable by employers on contributions in arrears.

(v) Donations and legacies.

" Hidden reserves " mentioned in paragraph 7 of Section B (*ante*) will be part of " annual surpluses " through which they will show themselves.

As regards the Epidemic Reserve Fund. this clearly is the responsibility of the State, which is entrusted with the general aspects of Public Health, such as preventiou of epidemics, etc. In any case, it is impossible for the Fund to bear the sudden strains caused by epidemics, whether they be localised or nation-wide. To meet the cost of such epidemics the Fund will have to call upon the Governments of the Provinces concerned and States if any, in the case of localized epidemics, and upon the Federal Government in the case of nation-wide epidemics, to pay special contributions from time to time into this Fund, as far as possible on the basis of principles regarding calculations of liability previously agreed upon.

There is one more point to be considered,viz., whether there should be any maximum or minimum limit to the size of these Funds. In practice, the criterion adopted in most laws to determine a minimum for the reserve fund is the order of the annual expenditure of the institution. It is necessary to lay down a statutory minimum to be attained within a stated period in order to safeguard the institution against sudden strains. As regards the maximum, there are usually two main motives, *viz.*, the desire to avoid immobilising too large sums in reserves and the desire to avoid extravagance and carelessness caused by the presence of large reserves. The maxima and minima for the two Reserve Funds, to my mind, should be the same, say, 3 years' expenditure in the case of the maximum limit and one year's expenditure in that of the minimum limit. The minimum in the case of the Contingencies Reserve Fund can be attained in less than 14 years on the assumptions of a 5 per cent. contribution, a rate of interest of 5 per cent., and constant expenditure over a series of years. When the minimum is reached. the aim should be to maintain the Fund above it. When the maximum is reached. the question will have to be considered whether any fundamental changes are necessary in the rates of contributions or in the scale of benefits. The Epidemic Reserve Fund, likewise, will have to be accumulated at a steady rate over a series of years, subject to the limits laid down.

E. Disposal of Surpluses.

Provision regarding actuarial valuation are necessary in countries. where a system of capitalisation is in use. Section 103 and 104 of the British Act for example. lay down the provisions regarding valuation of approved societies and the application of any surplus found after such a valuation. In these countries. the valuation, which is done by persons known as Valuers. with high actuarial qualifications. determines the extent of the true surplus which can be disposed of. On the other hand, in countries where the budgetary system has been adopted, as already stated, each financial year forms a separate and independent unit, and care is taken beforehand to see that the income and expenditure in the year more or less balance. In actuality, however, under this system. some of the financial operations continue in the next year's budget and hence it is not always possible to judge beforehand the exact amount that would have to be spent in the year on benefits or earmarked for reserves. Some unforeseen surplus of receipts over expenditure. or conversely a deficit. may be found at the end of the year. The problem of the disposal of surpluses thus arises. whatever system we may adopt. It is necessary therefore. to suggest provisions for the disposal of surpluses. In Great Britain. the surplus realised on valuation of the assets and liabilities of the approved societies is generally divided into two parts : one of them is attributed to reserves, while the other, known

as the " disposable surplus," is utilised for granting increased benefits during the subsequent period. Under the present scheme, also, the surpluses in any year should be either (*a*) devoted to the provision of additional benefits, or (*b*) credited to the Contingencies Reserve Fund. To the extent that the surpluses arise from sources which can be regarded as windfalls, they should be credited to the Reserve. If, however, any part of the surpluses appears to be of a current nature, it might be devoted to provision of additional benefits. The procedure to be adopted after the Reserves reach the maximum limit has already been discussed in Section D, above.

F. The Costs of Benefits and Administration.

It is difficult at this stage to discuss the financial implications of the scheme in concrete figures. The exact size of the expenditure under each of the three heads viz., cash benefit, medical benefit and administration will naturally depend upon the actual morbidity experience of the country as a whole, upon the type and extent of the administrative and medical machinery which will finally emerge, and particularly upon the successful operation of the various checks and balances provided in the scheme for minimising expenditure and preventing fraud and leakage of funds. I fully agree with the Actuarial Advisory Committee when they say (in their Report, para. 13) that " we are at present groping in the dark as to the essential elements entering into the calculations." All that can be done at this stage is to indicate the optimum level of contribution necessary to meet the probable expenditure and leave a margin of safety, reliance being placed on the available figures, both here and abroad, and on certain readily permissible assumptions. The statistical material presented in Appendices VI, XIII and XVII may be referred to here, I do not claim that the Indian figures are such that absolute reliance can be put on them, but comparing the data, I think we do get a range within which we are likely to find our sickness experience oscillating.

As the concerns which were approached for fiugures relating to sickness experience did not maintain statistics on a uniform basis, I had to content myself with getting what I could. Moreover, in some concerns, workers were examined medically before appointment, in others not ; in some concerns, leave pay was granted up to a certain maximum number of days (mostly not more than 15 days), in others no leave pay was available; in some, medical facilities were provided so as to keep down the rate of sickness, in others this was not done. The figures, again, refer in some cases to the number of days for which actual sick pay was granted and in others to the total number of days of sickness irrespective of sick pay leave. In view of this medley and at the instance of the Actuarial Advisory Committee, further details were obtained from important concerns so as to clarify the position. In the figures presented in Appendix VI, distinction has been drawn between rates of sickness for which sick pay was available (*net* rates) and those for which no sick pay was available (*gross* rates). Owing to the rules determining the payment of cash benefit in any establishment or scheme, the number of days for which cash benefit is payable is often a proportion of the total number of days for which the insured was sick in the medical sense. In the present scheme, also, in view of the rules regarding the " waiting period ", the " qualifying period ", " linking-up ", etc., the actual number of days for which cash benefit will have to be paid is far short of the maximum possible number of days of sickness. This fact is illustrated by the case of Japan, mentioned in Section B above. In Great Britain, the rates of sickness provided by the Ministry of Health are not for the total days of sickness but for the claims actually made and accepted. The Actuarial Advisory Committee rightly state (in para. 13 of their *Report*) that it is the " claims rate " to be watched rather than the

sickness rate. I have not, however, come across this important distinction anywhere in the literature on health insurance. *It is clear that the extent to which the gross rate can be whittled down to the net rate by means of rules of cash benefit will depend upon the features of each individual scheme of health insurance, and it is conceivable that the same gross rate may give different net rates under different circumstances,* Thus, for example, if under the present scheme, the " waiting period " is made retrospective in effect for cash benefit, or the maximum number of days is increased from 90 days to 180 days in the future, the net rate obtainable will be different.

The point to be noted in the present case is that the data for sickness incidence do not reveal a rate of sickness higher than 14.6 days (whether gross or net) anywhere amongst the concerns for which figures were available. In view of this, all that can be legitimately said is that the rate of contribution which provides, on the average, for a cash benefit of more than 14.6 days per annum per worker, is at the *optimum* level, if not at a *safe* level.

G. Government Guarantee.

At the Conferences of Labour Ministers and subsequently by negotiation the principle of financial guarantee for the stability of the health insurance fund was generally accepted. The proposal was presented in two different alternative forms (*vide* Labour Department Circular Letter No. L-3019, dated the 19th March 1942 to the Provincial Governments), *viz.;*—

(a) A guarantee to reimburse the Centre for advances granted by the Centre to an all-India fund on some pre-determined scale (*e.g.*, provincial contributions to be proportionate to number of persons insured);

(b) A guarantee to make the necessary advances to separate provincial funds.

In view of the fact that a single Central Fund was accepted and has also been suggested in this scheme, it is clear that the former alternative will have to be adopted. The procedure under which the guarantee will be made effective, the circumstances under which it will apply, and the manner in which it will be liquidated, will be as follows :—

(i) If during any year the disbursements of the Fund exceed the receipts, the Government of India will grant advances to the Fund to enable it to meet its commitments.

(ii) At the end of every five years at the time of the actuarial valuation, the Provincial Governments (and States, if any) will be called upon to reimburse the Centre for the total sums advanced during the previous five years. The Government of India will, of course, share this responsibility with regard to Centrally Administered Areas.

(iii) The loans advanced will carry a nominal rate of interest till they are fully repaid.

(iv) The allocation amongst the Provinces (and States, if any) will be on a *pro-rata* basis, *i.e.*, according to the number of insured workers in each Province (or State).

(v) The advances will be recouped from the fund out of the surpluses credited to the Contingencies Reserve, the accounts being settled at the time of the five-yearly actuarial valuation.

(vi) The surpluses will be brought about by means of suitable adjustments in the receipts and disbursements of the Fund, particularly in the contributions and benefits. If sufficiently large surpluses do not accumulate and at the time of the next actuarial valuation it is not possible to pay off all the

arrears of advances, the balance of the guarantee will be carried forward to the next following quinquennium, subject to the provision that the available surpluses may be employed in repaying the Provinces (and States, if any) in proportion to their outstanding loans.

(vii) The repayment of loans advanced under the guarantee will be a first charge on any surpluses that may arise at the time of the quinquennial actuarial valuation, and at law the guarantee debts will take precedence over all other debts incurred by the Fund.

(viii) When the Contingencies Reserve grows up to sizable proportions, the Government of India, in agreement with the Provincial (and State) Governments, may discontinue the gurantee by means of a notification.

The provision of a government guarantee is an attractive feature of the scheme, and I entirely agree with the Actuarial Advisory Committee that this should remain as long as it is necessary (subject to what has been said in para. viii above), even though the Governments concerned agree to a contribution. The liability of each Government is likely to be extremely small, as the deficit, if one arises, will itself be a small proportion of the annual expenditure ; and, moreover, the " guarantee " will be in the form of loans repayable after an interval together with interest.

If, however, the Governments concerned decide at any future date to terminate the guarantee, there are two alternatives open to us. As the guarantee involves nothing more than moneylending on moderate terms, the first and most obvious alternative would be to empower the Fund *to float loans* in the open market, like any other statutory body, preferably through the Reserve Bank of India. As the scheme will have the backing of Governments and as in the event of deficits arising it will be open to the Health Insurance Administration to raise the scale of contribution and/or reduce the scale of benefits, the credit of the Administration is not likely to be low in the money market. The second alternative is to empower the Administration to *reinsure* its total risks with commercial insurance companies in the open market and distribute the risks by inviting tenders from the companies on fixed terms, leaving them to decide the quanta of risks they are prepared to accept, or offering the entire risks to those whose terms are the most attractive in such quanta as they apply for. The question is whether private insurance companies would thus reinsure the risks of health insurance. It may be objected that the authorities would have little incentive left to manage their affairs on economical lines after they had reinsured with private companies. The force of this objection is vitiated by the consideration that if the authorities prove lax in their administration, the insurance companies on the next occasion, will demand higher premia. Thus, in any case, the authorities will have to manage their business economically. No doubt the basic assumption here is that the authorities are interested in minimising the total costs. But that is also the assumption of any other alternative that could be suggested and is fundamental to the whole scheme.

H. Accounting and Auditing.

The accounts of the Health Insurance Funds will be subject to the same rules as those of Government Departments and will be audited by Government Auditors. The accounts will be separately maintained for each Centre and Sub-Centre and pooled at the offices of the Central Board. In the case of the Reserve Funds, the accounts will be maintained only at the Central Office. The forms in which the accounts will be maintained will be prepared in due course. The cost of auditing will be borne by the Health Insurance Administration.

I. Investments.

In the ordinary course of affairs of the Health Insurance scheme, the authorities will be in charge of considerable sums of money and the problem must arise of the proper utilisation of these sums available for investments, after setting aside the amounts necessary to cover the cost of benefits and of administration. These funds are drawn mainly from compulsory contributions of a large section of employers and industrial workers and hence need to be regulated judiciously. Because of the large amounts involved and because of the fact that health insurance is a social duty, some form of regulation and direct supervision will be essential. Under this scheme, the Financial Branch of the Central Office of the Fund will be in charge of investments and of management of the Reserve as well as of all floating funds. The function of investment of the funds will be entrusted to the Central Board. However, though the Central Board may take upon itself the actual functions of investing the funds, it will have to do so in the light of the limits imposed by the Act. The Central Board shall lay down the regulations regarding investments, in conformity with the ideal laid down by the Correspondence Committee of Social Insurance, I.L.O.

" The regulations should be sufficiently precise to be used as a practical guide to the bodies responsible for selecting investments and wide enough to leave them sufficient liberty of action to serve them in the best way the interests of the insured community, while allowing, if necessary ..... for the interests of the national community."

While investing both long-term and short-term funds, various factors such as safety, yield, liquidity, economic and social utility, ease of administration and market tendencies will have to be taken into consideration. For this purpose a study of the permissible classes of investments for the funds in the laws of other countries will be found useful. For example, we might utilise with suitable modifications, the *British Health Insurance Act*, Sections 142, 143 and 158, as also the *Approved Societies Regulations*, 1938, Part IV, Rules 22 to 39. The problems will be much easier in India, because of the absence here of such institutions as the Approved Societies, the Deposit Contributors' Fund, the Navy, Army and Air Force Insurance Fund and the Exempt Persons' Fund. In the United Kingdom, out of the total amount of funds available for investment and standing to the credit of an approved society, the Minister withholds a half crediting it to " Investment Account " in the name of the society. With regard to the remaining half, the society may keep it with the Minister to be credited to the " Investment Account ", or request him to invest it on behalf of and in securities selected by the society, or by taking the sum over it may itself invest it in the names of its trustees in any security in which trustees are, for the time being, empowered by law to invest trust funds, or in stocks, mortgages, or other investments issued by local authorities. Under the present scheme, the investment of the funds will be in charge of one central authority and the problem of investment by approved societies naturally does not arise. However, for our purpose we can utilise the various classes of investments permissible under and defined by the National Health Insurance Act of Great Britain. Section 158 of the Act refers to " any securities which are for the time being authorised by Parliament as investments for Savings Banks funds," preference being given to " stocks or bonds issued under the provisions of the Acts relating to borrowing or raising capital for the purposes of the local Loans Fund where the purpose for which the capital is required is the making of advances for the purposes of the Housing Act, 1936." Section 143 (1) grants to an approved society " power to invest in any investments in which trustees are for the time being by law empowered to invest trust funds, or in

any stocks, mortgages or other securities issued by any local authority within the meaning of the Local Loans Act, 1875, and charged on any rates levied by or on the order or precept of that authority, or in any other securities for the time being approved by the Minister."

In the light of these provisions, we can also decide upon the permissible classes of investments regarding the funds collected under the present scheme. *Safety* is the first condition that is to be observed, which means that the value of investments should be " secure as regards the recovery or conservation of the nominal value of the capital invested and the regular receipt of interest." To ensure the highest possible degree of safety the meeting of the Committee of Experts of the I.L.O. laid down that the regulations should set out a general definition of the conditions to be observed on the selection of investments, draw up an exclusive list of the classes of investments which accord with the general definition and to prescribe an appropriate distribution of the investments among the various classes included in the list. From the standpoint of undoubted safety, Government loans or Government guaranteed loans are particularly suitable and hence statutory provision should be made that a certain percentage of the sums available for investment should be invested in these securities. Section 27 of the Insurance Act of 1938, for example, lays down that every insurance company must invest and hold invested assets equivalent to not less than fifty-five percent of the sum of the amount of liabilities to holders of life insurance policies in India in the following manner : twenty-five per cent. of the said sum in Government securities and a further sum equal to not less than thirty per cent. of the said sum in Government securities or other approved securities or securities of or guaranteed as to principal and interest by the Government of the United Kingdom. This provision, after suitable modifications, can be applied to the Health Insurance Funds, and they can be invested in part (say 50 per cent.) in the Loans issued by the Central and Provincial Governments as well as in securities issued by the Secretary of State for India under the authority of British Acts and charged on the revenues of India. Loans raised by municipalities, local boards, public utility concerns, and such other public bodies, which have unquestionable and sufficient guarantee behind them, should also be considered particularly suitable for investment purposes.

Next to safety, there are two other important factors to be taken into consideration,—*yield* and *liquidity*. The investments must result in the highest possible yield in consonance with safety and with liquidity. In course of time, the interest on investments becomes an important asset to the Funds. The accounts of the National Health Insurance of Great Britain shows that in 1938-1939 the income from investments amounted to £6,379,000, out of the total receipts of £44,347,000. For a higher yield, it is sometimes necessary to invest in variable-yield securities, such as high-grade commercial and industrial shares (ordinary) or stock or in urban and rural property. The income from these sources often fluctuates and hence a thorough knowledge of the conditions of the money market is essential. With safety as the first consideration, investments can be made in loans of Land Mortgage Banks or Buildings Societies and in commercial or industrial debentures, because the yield here is fixed and often higher than in Government loans. The factor of liquidity demands that a certain proportion of the funds should be invested in short-term securities. The principle of contingencies reserves implies that such reserves should be capable of immediate realisation.

A factor which distinguishes social from commercial insurance, is the *economic and social utility of the investments*. The funds can be utilised not only for the development of the worker's standard of life but also for the furtherance of the ultimate aims of health insurance itself. In fact, in foreign

countries, this factor is often kept in view by those in charge of investments. (Cf. *Investment of the Funds of Social Insurance Institutions*, pp. 48ff.) Loans can be given for the purposes of other schemes of social assistance and social insurance and well-planned schemes of housing, co-operative societies, employment and health of industrial workers. The health insurance funds can be invested, for example, in the construction of premises for the various services of the Fund such as office-buildings, dispensaries and hospitals, sanatoria, and homes for the sick ; they can be utilised also in the purchase or building of dwellings for insured workers, which will be the property of the Fund, producing a suitable yield. These dwellings, which may form part of a housing scheme, may be sold to the insured, who for this purpose may obtain a mortgage loan from the Fund bearing interest at a fixed rate and repayable in a certain specified number of years. A part of the Funds should thus be utilised for making loans to the insured workers, who have a certain number of years' service to their credit, for some specific purposes such as building a house, etc. Such loans, not exceeding a certain limit, may be given at a fixed rate of interest to workers on their furnishing a security or as mortgage loans, the amount of loan being proportionate to their wages. With the help of public institutions, the funds can be utilised for carrying out an extensive programme of public works to relieve unemployment, or for maintaining public health in industrial areas, or to prevent loss or reduction of the working capacity of the insured. To this purpose, loans can be made also for land improvement, drainage and irrigation or hydraulic works, provided, as in all the cases referred above, the competent authority considers the loan to be sufficiently safe.

J.—Actuarial Valuations.

(i) There will be an Interim Actuarial Enquiry at the end of the first two years in the light of the statistical and other experience gained. This interim enquiry will not concern itself with alteration in rates of contributions and benefits but mainly with a study of the trend of events in the progress of the scheme, and will also make suggestions, if any, for tightening up administrative, actuarial and auditing control over the affairs of the Fund.

(ii) At the end of the first five years, and every five years thereafter, there will be an actuarial enquiry and valuation for the purposes of (*a*) allocating the liability of each Government under the guarantee, (*b*) making proposals for alterations, if any, in the scheme of contributions and benefits, and (c) making suggestions relating to matters already covered under (i) above.

(iii) Apart from these periodical valuations, the Actuarial Branch of the Fund will keep itself fully acquainted with the trend of events and will continuously collect and analyse data, with a view to the actuarial and statistical control of particular areas and localities. If at any time it is found that the affairs of the Fund are getting financially involved, it will be open to the Competent Authority, in the light of investigations carried out by the Actuarial Branch, to institute an immediate actuarial enquiry and valuation of the kind suggested in (i) or (ii) above.

Chapter VI.

THE ADMINISTRATIVE MACHINERY.

In this Chapter, I shall describe the constitution, functions and responsibilities of the Administrative Machinery to be set up. I have given considerable thought to the problem of the appropriate machinery of administration, which would be found suitable under the special circumstances arising in this

country. As may be seen from the following paragraphs a system of administration having a *territorial basis* and adequate representation of various parties on the administrative bodies to be set up, is likely to be found more suitable than other patterns in India.

A. The Problem of Administrative Machinery.

Various types of administration can be considered with regard to Health Insurance : (*a*) Friendly Societies, (*b*) Trade Unions, (*c*) Specially created bodies.

As regards Friendly Societies, this type of administrative bodies was found suitable in some of the European countries, such as Great Britain and Germany. The advantages of this system are, firstly, a close contact between the insured and the administration, and secondly, the personal interest which the insured workers are likely to take in the prosperity of the Friendly Society. It is not, however, necessarily a faultless system on that account. It has been pointed out by Mr. J. L. Cohen, in his *Social Insurance Unified*, p. 35, *et passim*, that " It is a farcical pretence that these approved societies are democratically controlled. No one is taken in, and parliamentary authority suffers in consequence. Insured members are indifferent, and the committees of management are permanent or can easily procure the election of those whom they desire..... And of all the errors made during the period of excitement, recriminations, threats and strikes which accompanied the birth of the scheme, none was worse than the recognition of these societies." Apart from this, another great abuse has arisen. As pointed out by Sir Frederick Stewart, formerly Parliamentary Under Secretary for Employment, in his Report on *Social Insurance*, presented to the Australian Government, in 1935 (p. 7), and recently with still greater authority by Sir William Beveridge in his *Report on Social Insurance and Allied Services*, Vol. I, pp. 23-28, the British system of individual societies has led to a serious lack of uniformity in the provision of insurance benefits. Sir William Beveridge observes : " Reconsideration leads to the conclusion that the approved society system in its present form has served its purpose and has had its day. Without belittling in any way the services rendered by all kinds of societies in the launching of health insurance, it is possible to decide that the time has come to make health insurance national. The reasons leading to this conclusion may be summed up under two heads : first, that the approved society system is inconsistent with the policy of a national minimum ; second that the approved society system has disadvantages for insured persons and involves unnecessary administrative costs, while the compensating advantages which it may provide for such persons can be obtained in other ways." In this connection, it is worth quoting the view of the British Trade Union Congress (*vide* their Memorandum to Sir William Beveridge, reproduced in Ann. G of the Beveridge Report, p. 13) : " If they happen to be an Approved Society that has had heavy sickness claims, and is, therefore, carrying out the intention of the Act, then the members of that particular organisation may find themselves not only carrying the national burden but penalised for doing it by having a reduction of benefit, whilst the members of other Approved Societies, merely because they had a luckier experience, are entitled to higher benefits. Thus, *the scheme does not provide the highest benefit for those who need it most, but for those who need it least.*" (Italics mine). It is, therefore, clear that the principle of matching risks with premiums, which is implicit in the approved society model, may satisfy equity in the commercial sense, but hardly equity in the *social* sense. Sir Alfred Watson speaking at the Eighth International Congress of Actuaries (*Proceedings*, Vol. V, p. 211) remarked : " In Great Britain, we have general societies covering the whole country, and taking in persons of every trade and occupation. On the other hand, we have

purely local societies, drawing the membership from a very small area. Further, we have societies connected with particular occupations or industries, often, but not invariably, constituted on a trade union basis. Again, societies have been formed on the basis of a particular qualification for membership, such as total abstinence, or membership of a certain religious community, while another class consists of societies, whose members are employed by particular firms or companies. There are, thus, the greatest possible contrasts to be found in the societies working under the British system." From these remarks, it is obvious that the approved society principle is not based upon any unique morbidity experience of a well-defined group, but in fact accommodates itself within a conglomeration of sickness rates. A general society " covering the whole country " and taking in persons of every trade and occupation, is really a microcosm of the Central Fund idea, in so far as, under both, insured workers possessing widely disparate rates of sickness experience are catered for under one unit. This is precisely what Sir William Beveridge has in mind when he recommends that " men stand together with their fellows." Rightly has the British model been described (I.L.O. Publication, Series M. 18, *Approaches to Social Security*, pp. 25 ff.) as " a survival of medieval corporative tradition ", and as having led to the maintenance of a " multiplicity of small societies difficult to regiment into conformity with the stringent administrative exigencies of a national compulsory scheme." It has been at best a political compromise with the existing situation under which the powerful Friendly Societies, Trade Unions, and other bodies could not be ignored, and while their practical experience has been a valuable asset, on the whole, the system has led to inconsistency and mismanagement. I am not, therefore, inclined to regard the absence of Friendly Societies or similar bodies in India as an unmixed evil for we can build here on a rational basis, without complicating our task by the creation of a multiplicity of societies.

Nor am I in favour of assigning the administration of health insurance to Trade Unions, for, although they can be said to represent the beneficiaries under the scheme, their present organisation is so poor and rickety that it would be extremely hazardous to entrust the management of health insurance funds and benefits to them. Nor, on the other hand, can we entrust it to the employers for obvious reasons. Some of the other alternatives are not likely to appeal to anybody. For example, local boards, municipalities, and such other civic bodies can hardly be trusted to do justice to this work. The model which appears to meet with the approval of the majority of those with whom I had discussions, as also those who have replied to the Questionnaires, is one in which all the different parties to health insurance will find adequate representation.

The kind of system proposed here will, therefore, combine, (*a*) a territorial basis, (*b*) appropriate representation of the contributing parties, beneficiaries and the medical profession, and (*c*) unification and centralisation of funds which is not inconsistent with local management. Here it may be pertinent to point out that the territorial basis (as opposed to the industrywise basis) is being increasingly favoured abroad as meeting the special requirements of *social* insurance. Representation of the various interests concerned on the administrative machinery is also a development along right lines. The I. L. O. Sickness Insurance Convention (I. L. Code, Art. 502) enjoins that " Sickness Insurance shall be administered by self-governing institutions, which shall be under the administrative and financial supervision of the competent public authority.....". As regards unification and centralisation, the reasons which have led me to suggest these are (*a*) " pooling of risks ", which is the essence of social insurance, (*b*) co-ordination of medical services and policies, including research, prevention, etc., and (*c*) uniformity of standards, which is essential not only in the interests of labour but also in those of industries and their

economic localisation. Centralisation does not, however, rule out a measure of local independence ; it is all a question of distributing functions in the most appropriate manner between the central body and the peripheral bodies.

B. The Constitutional Position.

Under the Government of India Act, 1935, " health insurance " falls in Item No. 25 of the Concurrent List, Part II. Under Section 49, the executive authority of a Provincial Government extends to all matters with respect to which the Provincial Legislature has power to make laws, and hence to all items of the Concurrent List. On the other hand, under Section 313, the administrative authority of the Federal Government is restricted to matters falling in the Federal List, although under Section 126 (2) the executive authority of the Federation extends, subject to certain conditions, to " the giving of directions to a Province as to carrying into execution therein of any Act of the Federal Legislature which relates to a matter specified in Part II of the Concurrent List and authorises the giving of such directions ". Thus, it may appear that the Act vests in the Federation somewhat greater authority in respect of Part II of the Concurrent List than in that of Part I, inasmuch as while Part I enables it merely to legislate, Part II empowers it to issue administrative directions to Provinces. Thus, if the Federal Legislature passes a Health Insurance Act for British India as a whole, the administrative authority of the Government of India will be restricted to issuing directions to Provinces. This means that neither the Labour Department nor any other Department of the Government of India can exercise any administrative control over the organisation that might be set up. If the organisation is split up into Provincial bodies, the Provincial Governments, however, can control them. Paradoxically, moreover, while the Government of India can issue directions to the Provincial Governments, it cannot do so to its own creature, *viz.*, the Central Organisation of Health Insurance ! What strikes one as of tremendous importance is the fact that practically all measures of the future Social Security programme, such as unemployment insurance, old age and invalidity pensions, workmen's compensation, etc., are in the same position as health insurance, as they are all part of Concurrent List, Part II. This, it appears to me, is going to be a matter of serious consequence to the administration of future social security schemes. If centralisation is aimed at,—and this is quite essential,—the only remedy under the circumstances appears to be to set up Statutory Corporations under special Acts of the Central Legislature. Under Item 33 of the Federal List, " corporations, whether trading or not, with objects not confined to one unit,", are a subject within the competence of the Federation. There may not, therefore, be much difficulty in erecting a statutory body under that item. At the same time, I may be permitted to state that the device of an independent central corporation, not under the control of any Government, is one which is likely to complicate affairs considerably when other schemes of social security are to be put into operation. One cannot think of half-a-dozen different corporations dealing with different aspects of social security ! When the Government of India Act was drafted, these issues were probably not very clear, and also the foreign constitutional models were not very helpful ; but now that social security programmes are on the anvil and these imply certain basic conditions, it is for consideration whether the Centre should not have more powers than those of mere issue of directions to Provinces, in regard to these items in Part II of the Concurrent List. If the view is accepted that like everything else, in the post-war period, the Indian Constitution will also be in the melting-pot, it might be useful to keep an eye on the possibility of getting this part of the Act amended.

It should be possible to control the Statutory Corporation in an indirect manner. Administrative affiliation of the Corporation to any Department not

being feasible, control may have to be exercised in three indirect ways : (1) Ultimate control, *i.e.*, through amendments, etc., in the Health Insurance Act setting up the machinery ; (2) financial control, *i.e.*, influencing decisions of the Health Insurance Administration by modifying the financial assistance to be given by the Government of India by way of contributions, subsidies or guarantee ; and (3) control by representation, *i.e.*, influencing the day-to-day administration of the scheme through representatives nominated by the Government of India (as well as by other parties, including the Provincial Governments, employers and workers, and the medical profession). In devising the administrative machinery, I have kept all these three forms of control in view. It is clear that the Provincial Governments (and States, if they join) should have appropriate representation both at the centre and in the regional bodies to be set up. The assistance of the Provincial Governments (and States) will be necessary in putting the scheme into force, especially on the medical side. The Statutory Corporation to be set up may be authorized to enter into agreements with Provincial Governments, Municipalities and other public institutions in regard to utilisation of any existing medical facilities, such as hospitals and clinics. Finally, with a view to co-ordination of practices throughout India and securing uniformity, the Government of India should be in a position to issue directions to Provincial Governments along lines of Section 126 (2) of the Government of India Act.

C. The Statutory Corporation.

The structure of the Statutory Corporation, which may be styled the Central Board of Health Insurance, will be broadly as follows. There will be an administrative pyramid with the Central Board of Health Insurance at the apex and Regional Boards and Local Committees below. For administrative convenience, the country will be divided into Regions, which in some cases (*e.g.*, Bombay, Bengal, Madras, Punjab, U.P.) may be the same as Provinces, and in others, combinations of Provinces (*e.g.*, Bihar and Orissa, N.W.F.P. and Sind, joined to the Punjab ; Assam joined to Bengal and so on). This is necessary as some of the Provinces and many of the States will have such an insignificant number of insured workers that it may be impossible to establish costly administrative machinery on a provincial or state basis. I do not propose to specify the Regions at this stage, as this can be done later under the Act itself. In each Region, there will be Health Insurance Centres and Sub-Centres and there will be a Local Committee for each Centre or Sub-Centre. Each Region will also be divided into Divisions for the purpose of medical supervision, inspection and propaganda. The Central Board, the Regional Boards and the Local Committees will each have offices attached to them. All these will form the Statutory Corporation which will be entirely a self-contained organisation bound alone by the Act constituting it and maintaining contact with the various Governments and other parties through their respective representatives.

D. Constitutions of the Central Board, the Regional Boards and the Local Committees.

The *Central Board* will consist of the following :—

(1) The Hon'ble Member in charge of the portfolio of Labour (Chairman).

(2-5) Four representatives of the Government of India (two from the Labour Department and two from the Education, Health and Lands Department).

(6-9) Four representatives of the Governments of the Regions (by rotation).

(10-12) Three representatives of Employers.

(13-18) Six representatives of Workers.

(19) Commissioner of Health Insurance.

(20) Medical Commissioner.

(21) One representative of the Medical Profession.

(22-24) And such other non-officials (not exceeding three in number) as H.E. the Governor-General in Council may from time to time appoint. (Of these at least one may be a woman member).

The Central Board will constitute itself into two principal Committees (and other sub-committees according to requirements). The principal Committees are the Executive Committee, which will deal with all non-medical matters, and the Medical Committee, which will deal with medical matters. It should be obvious that the former will consist mainly of non-medical members of the Board and the latter of medical representatives. The Executive Committee will consist of the following : (1) The Chairman of the Central Board, (2-3) representatives of the Labour Department, (4-5) two representatives of the Regions, (6) one representative of employers, (7-8) two representatives of workers, (9) the Commissioner of Health Insurance, and (10) one non-official member, The Medical Committee will consist of the following : (1) The Chairman of the Central Board, (2-3) representatives of the Education, Health and Lands Department, (4-5) two Regional representatives, (6) the Commissioner of Health Insurance, (7) the Medical Commissioner, (8) the representative of the Medical profession, and (9) one non-official member. All official appointments, other than medical appointments, will be made by the Executive Committee, while all medical appointments will be made by the Medical Committee.

The *Regional Board* of each Region will consist of the following :—

(1) Minister of Labour in the Region (if this is a Province, or by rotation if it is a combination of Provinces).

(2-3) Two representatives of the Provincial Government or Governments (by division or rotation).

(4-5) Two representatives of Employers.

(6-9) Four representatives of Workers.

(10) Deputy Commissioner of Health Insurance for the Region.

(11) Chief Medical Officer of the Region.

(12) One representative of the Medical Profession.

(13-15) Such other non-officials not exceeding three in number as the Chairman of the Central Board may from time to time appoint (one at least being a woman).

The Regional Board will act in an advisory capacity and unlike the Central Board, it will exercise no executive authority. In the Region, the executive authority will vest in the Deputy Commissioner of Health Insurance, who will be under the control of the Commissioner of Health Insurance. Normally, however, the Deputy Commissioner of Health Insurance will act on the advice of the Regional Board, and the cases in regard to which he would be free to act otherwise will be determined by conventions or regulations. The Regional Board will also have committees and sub-committees to deal with different matters.

The Local Committee of each Health Insurance Centre and Sub-Centres will consist of the following :—

(i) Six representatives of the Insured workers.

(ii) Three representatives of the employers covered by the Act.

(iii) One representative of the medical profession.

(iv) One representative of the Municipality or Local Board of the area.

(v) The Administrative Officer of the Fund (*ex-officio*).

(vi) Such other persons (not exceeding three in number) as the Chairman of the Central Board may from time to time appoint.

The Chairman and Vice-Chairman will be elected by the Committee themselves. The Fund's Officer will not be eligible for these positions.

The workers' and employers' representatives will be elected in every Centre and Sub-Centre at a special poll taken every five years provided that, *in the first instance* the Chairman of the Central Board will nominate them after consultation with such employers' and workers' associations as he may choose for this purpose. The representative of the medical profession (who must not be a Fund's doctor) will be nominated by the local medical union or association recognised for the purpose, and if this does not exist, by the Chairman of the Central Board in his own discretion.

E.—Functions and Responsibilities of the Various Bodies.

(i) *The Central Board.*—This will be the supreme authority of health insurance and will (a) control the affairs of the entire Health Insurance Administration, (b) be the custodian of its funds and have powers to invest, borrow and repay, (c) decide all questions of policy in regard to health insurance, (d) issue directions to Regional Boards and Local Committees in regard to the carrying out of decisions and policies, and (e) make all appointments in the all-India cadre of health insurance at its own initiative and all appointments in regional cadres on the recommendation of Regional Boards. The Commissioner of Health Insurance, who will be appointed by the Central Board, will be the chief executive authority and all decisions of the Central Board and its Committees will be carried out by him. As he will be, by dint of his membership, in constant touch with the Executive and Medical Committees of the Board, he will be in a position to do this without difficulty. Broadly speaking, the Medical Committee will make all all-India appointments in the medical sphere and in doing so will draw upon the existing Indian Medical Services whose officers may be officers on loan to the Industrial Medical Service as also upon the higher strata of the Provincial Medical Services. I am not, however, in favour of any reservation of posts for either services, and I recommend that the Medical Committee should be free to draw upon independent sources of recruitment. If any officers are taken on loan from the existing medical services, they would enjoy the same privileges as other officers appointed in the health insurance cadres. The Central Board will also make all appointments in the Regional cadres, whether executive or medical, after taking into consideration recommendations made by the Regional Board in each Region. Here again, the Central Board may draw upon the existing Provincial services, but while the officers of the Provincial services are here, they will enjoy the same privileges as any other officers of the same rank in the health insurance services.

(ii) *The Regional Boards.*—The Regional Boards will (a) advise the Central Board and its local chief officer, viz., the Deputy Commissioner of Health Insurance on matters falling within the territorial jurisdiction of the Region, (b) in particular, supervise the administration of Centres and Sub-Centres, (c) make provision for and maintain the medical facilities as required under the Act, out of funds provided by the Central Board for the purpose, and (d) co-ordinate and execute, through the Deputy Commissioner of Health Insurance, all policies laid down by the Central Board, throughout the Region. Here, as stated earlier, the Deputy Commissioner will be the chief executive authority,

controlling both non-medical and medical matters, and all orders of the Central Board in regard to all these will be executed by him through his subordinates.

(iii) *The Local Committees.*—These will be the bed-rock of the whole system. Their functions will be numerous and of a detailed character. The Offices of the Centres and Sub-Centres will be supervised by the Committees, who will advise them on all matters. The Committees will keep themselves fully informed about the financial condition of the Centre and bring any discrepancies to the notice of the Officer, who must take action to correct the same. Each Committee will appoint suitable Sub-Committees for attending to different matters, e.g., matters such as Scrutiny of Claims, Settlement of Disputes and Adjudication of Offences, Finance, Medical Treatment, etc., will each have a separate small Sub-Committee for disposal of business. Moreover, members of the Local Committees will all be Sick Visitors, *ex-officio*.

F.—Classification of Industrial Areas.

Where there is an insignificant number of insurable workers employed in any particular area which is also remote from other industrial centres, the provision of health insurance will provide a difficult problem. In such areas, to be called " Sparse Areas," not only is the total cost of benefits likely to be higher than the total contributions arising in the area, but the administrative and medical costs will be forbidding, as compared to the actual advantages gained by the workers. It would thus be clearly wasteful to have a Centre or even a Sub-Centre at such places. Intermediate would be the case, however, of areas which contain a sufficient number of workers to justify a small office or sub-office for administration and where the Panel System may be conveniently adopted (as suggested in Chapter VI, Section B).

The Competent Authority, acting on the advice of the Regional Authorities, must decide the classification of industrial areas, according to the factors of distance and density, under the following groups :—

(i) Class I Areas, which may be called " Compact Areas " where the insured population is so large (e.g., Bombay, Calcutta, Cawnpore) that a large number of Centres can be established in a compact geographical unit, providing a Health Centre or Centres for them jointly.

(ii) Class II Areas, wherein individual Centres can be opened on an economical basis, providing not only an administrative office but also a " Dispensary " but not a " Health Centre ".

(iii) Class III Areas, where the number of insured workers justifies the opening of a Sub-Centre, where only a Sub-Office can be established, but where the medical treatment must be entrusted to Panel doctors.

(iv) Class IV Areas, also called here " Sparse Areas ", where the number of insurable workers is so small that the maintenance of even a small Sub-Office would be a waste (e.g., in some places, where there are small power-loom factories or engineering workshops, employing no more than 20 or 30 persons per unit and where the total number does not exceed, say, 500, it might be wasteful to have a Sub-Centre).

Two questions arise out of the foregoing :—

(i) What approximately should be the number of insurable workers deciding the class of any particular industrial area ? (ii) What provision should be made in the case of Class IV or " Sparse " Areas, so as to put them on par with other areas in regard to medical and sick-pay facilities ? These questions have been answered elsewhere. (See Chapter I, Section B, Chapter VII, Section B, and Chapter IX, Section F). In deciding the class of an area, we shall have to consider (a) the number of patients that a whole-time medical officer

of the Fund can manage, (b) the proportion of the total contribution which may be considered as " safe " for incurring the costs of maintaining an Office or Sub-Office, and (c) the minimum expenditure which will have to be incurred to establish and maintain a Dispensary and a Sub-Office. It is difficult to be dogmatic in this connection, and the exact conditions which must be satisfied before an area qualifies itself for inclusion in a particular class, can only be specified at a later stage. Provisionally, however, in the light of foreign experience and personal discussions, I am inclined to think that the following conditions will be satisfactory :—

(i) *Class I Areas.*—" Compact Areas "—will be those in which within a geographical area of, say, 25 square miles an insured population of at least 50,000 workers is covered. (Administrative Centres or Centres—Health Centre or Centres).

(ii) *Class II Areas*—will be those in which within a geographical area of 25 square miles, not less than 5,000 nor more than 50,000 insurable workers are to be covered and where individual Centres with Dispensaries can thus be opened. The minimum number for a Dispensary being 5,000 (Administrative Centre, Dispensary or Dispensaries).

(iii) *Class III Areas*—will be those in which not less than 500 nor more than 5,000 workers are insurable within 25 square miles (Administrative Sub-Centres—Panel Doctors).

(iv) *Class IV Areas*—" Spare Areas "—will be those in which less than 500 workers are insurable within 25 square miles. (Excepted).

It will be apparent from the foregoing that the relation between medical and administrative centres is not exactly parallel. Thus, one " Health Centre " may be catering for several Administrative Centres, but a " Dispensary " or several Dispensaries will cater for only one Administrative Centre, while a " Panel Centre " will correspond to one Sub-Centre only. The essential point to be grasped is that the financially economical or optimum size of a medical unit (whether it is a Health Centre, Dispensary or Panel Centre) is not the same as the optimum size of an administrative unit. Hence the relationship between the medical and administrative units must be decided in each case according to distance, density, and number (of insurable population).

G.—The Personnel and Functions of the Central, Regional and Local Offices.

Parallel to the semi-advisory, semi-executive machinery just described, there will be the Central, Regional and Local Offices of the Fund. These will be administratively controlled by the Commissioner of Health Insurance. The personnel and functions of these Offices will be as follows :—

(i) *The Central Office.*—The Central Office will have five main Branches : (1) Medical Branch, (2) Financial Branch, (3) Actuarial and Statistical Branch, (4) Propaganda, Information and Inspection Branch, and (5) Regional Branch. The constitution and functions of the Medical Branch consisting of the Medical Commissioner and his Office will be described in Chapter VII. The Financial Branch will attend to all financial matters, including (a) the consolidated accounts of the Health Insurance Administration, as well as of the Regions, Centres, and Sub-Centres, (b) the allocation and supervision of medical expenditure in the four Regions, (c) budgetary control of the entire organisation, (d) investment and management of the Reserves as well as of all floating funds, and (e) matters relating to the Guarantee and other debts. The Actuarial and Statistical Branch will have a full-time Actuary, assisted, if necessary, by junior Actuaries, specialised in Social Insurance, and will be concerned with

the collection, analysis and utilisation of all statistics relevant to health insurance, as also with the actuarial and statistical control of the entire scheme as well as individual Centres and Sub-Centres. The Propaganda, Information and Inspection Branch will be concerned with (a) health propaganda, (b) the mass education of workers in the purposes, methods and advantages of health insurance, (c) supervision of the work of Propaganda Officers in the various Divisions, and (d) the central direction of Inspectors in the various Divisions. The Regional Branch will attend to all matters affecting the Regional Administration of health insurance.

The administrative head of the Central Office will, of course, be the Commissioner of Health Insurance. He will be assisted by one Deputy Commissioner, two Assistant Commissioners, four Officers and staff. The Medical Commissioner and his staff will be subordinate to him.

(ii) *Regional Offices.*—There will be two Branches of each of the Regional Offices of the four Regions, (a) Administrative Branch, and (b) Medical Branch. The Administrative Branch will be concerned with the co-ordination and execution of policies centrally laid down and as supplemented by the Regional Boards, with the administrative control of the Offices of the Centres and Sub-Centres, with the maintenance of accounts for the Region and other financial matters, etc. The Medical Branch will be concerned with the provision of medical facilities and all matters relating thereto.

The administrative head of each Regional Office will be a Deputy Commissioner of Health Insurance, who will be assisted by one Assistant Commissioner, two Officers and staff. Side by side, there will be the Chief Medical Officer with his Office, who will work in collaboration with the Regional Office.

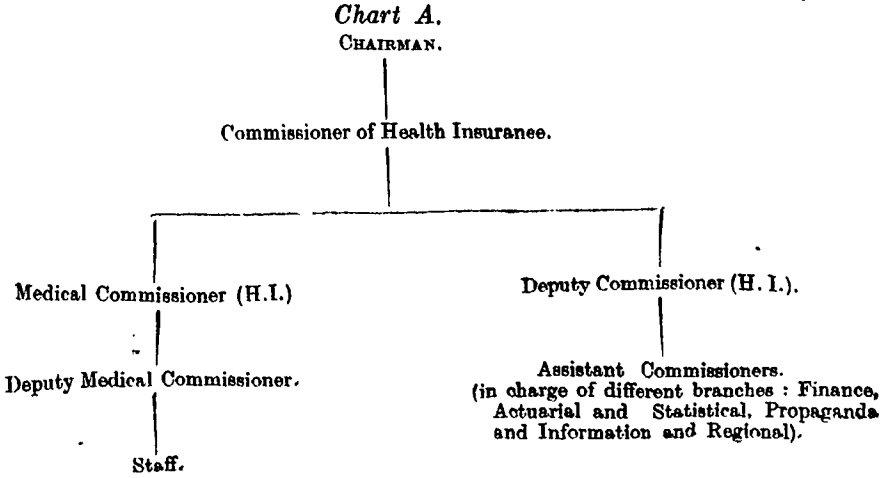
(iii) *Local Offices.*—Each Local Office of a Centre or Sub-Centre will be concerned with (a) sale of insurance stamps ; (b) issue of insurance cards of different kinds as required under the Act ; (c) maintenance of contribution registers ; (d) preliminary scrutiny of claims ; (e) payment of cash benefits and maintenance of cash benefit registers ; (f) all office matters relating to the Health Centres, Dispensaries or Panel Doctors, maintenance of medical benefit registers ; and (g) sick visitation reports and action thereon, and other relevant matters.

In each Centre, there will be an Officer of the Fund, assisted by one Accountant, one Cashier and small staff.

In each Sub-Centre, there will be an Assistant Officer assisted by a small staff only.

The following Charts broadly illustrate the position :—

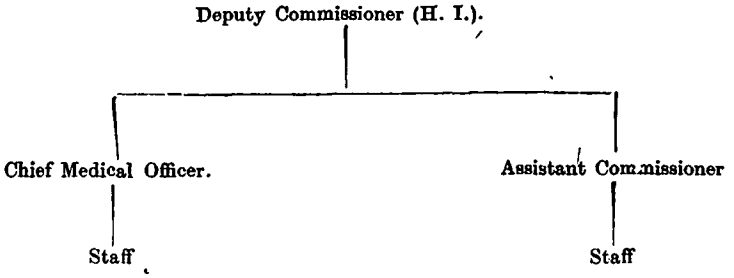
Chart A.


CHAIRMAN.
Commissioner of Health Insurance.
Medical Commissioner (H.I.)
Deputy Commissioner (H. I.).
Deputy Medical Commissioner.
Assistant Commissioners.
(in charge of different branches : Finance, Actuarial and Statistical, Propaganda and Information and Regional).
Staff.

I.&I.S.Dof.L.

Chart B.

Regional Administration



The medical machinery of the scheme and the functions of each category of staff will be described fully in the next Chapter.

H.—Scrutiny of Claims.

Upon making a claim for cash benefit, an insured worker shall, if so required, produce his card to the Office. Ordinarily, the Office will be in a position to ascertain whether the worker is or is not entitled to cash benefit on the basis of evidence obtainable from the Contributions and Benefits Registers, and the worker will be required to produce his card only where doubt exists as to this matter.

As soon as a claim for cash benefit, duly supported by medical certificate is made, and if the records in the office show that the worker is entitled to receive cash benefit, it will be paid by the Office forthwith on the day of presentation of the claim. If there is any doubt, the worker's contribution card will be required. It will thus be always safer for the worker to obtain his contribution card from the employer, if the latter is allowed custody by him, and to support his claim. Payment of cash benefit will be made for the period up to the date on which cash benefit is paid, provided of course incapacity is still present. If incapacity continues, further payments will be made every week on the same day of the week as the day on which the first payment was made, and the payment will be for the period of incapacity.

All claims for cash benefit which are satisfied will be conveyed to the Sick Visitor (or Visitors) concerned with the area, who will be required to see that there is no malingering. All such claims, together with reports of the Sick Visitor will then be placed before the Claims Sub-Committee of the Centre. Likewise, rejected claims also will be so placed. In every case, reasons for acceptance or rejection will be fully stated. If it is discovered that any worker has prepared a false claim, it will be a matter for judicial action. If, on the other hand, a worker has been wrongfully deprived of his dues, the Claims Sub-Committee might order the office to make the necessary emendation. It will be the duty of this Sub-Committee both to prevent the worker from committing fraud or malingering, and the office from bothering the worker with red-tape and routine.

The fact that a medical certificate has been submitted is not by itself sufficient to constitute proof of sickness. However, it will not be open to the Fund to refuse cash benefit unless there is independent *medical* evidence or clear proof that the worker was malingering (for example, if he did any work for wages or exerted himself in a manner which contradicted his claim of sickness).

The Sub-Committee will decide the issue ordinarily, but if there is any dispute, it will be referred to the appropriate judicial authority. (See Chapter VIII).

I.—Propaganda and Information.

It has been suggested that illiteracy might prove a stumbling-block in the way of administering the benefits and that ignorant workers might be either defrauded by intermediaries or others, or fail to seek proper benefits obtainable under the scheme. So far as the difficulty of administration is concerned, it could be partly removed by the requirement that the cards should contain either the signature or the thumb impression of the worker in either case duly attested by another person known to the worker. Thus, the problem of identity is not likely to be serious, just as (e.g.), it is not serious in the case of post-office savings banks. A far greater difficulty, however, would be that owing to illiteracy workers might not be able to understand the rules and regulations of the scheme, and claims might not be put up at all or wrongly put up on their behalf. This difficulty would no doubt arise especially in the initial stages of the scheme. It is not, however, wholly insuperable. Many illiterate persons can operate their postal savings bank accounts without much difficulty. Of course, the procedure there is much simpler. This, however, argues in favour of not only making our procedure as simple as possible, but also in favour of educating the illiterate worker in the rules and regulations of health insurance. The greatest possible endeavour has been made in the present scheme to achieve simplification in regard to its contents, consistently with the basic principles of health insurance. In the light of future experience, further attempts might also be made in that direction. So far as clarification of the scheme to the beneficiaries is concerned, however, the Propaganda Branch must attend to the dissemination of information amongst the workers regarding their rights and liabilities under the scheme. For example, at the very outset that Branch might bring together in a very simplified and concrete form all the rules of business of health insurance and publish them in a "guide." Similarly, it may from time to to time send out its men to acquaint workers and their representatives in important industrial centres with the rules and may maintain enquiry offices or clerks at such centres, as part of the health insurance offices, to help workers and others seeking information on any doubtful points. It may also be legitimately expected that Trade Unions would be playing an important part in assisting the workers in realizing their dues and also in generally keeping them alive to their own rights.

At smaller centres, the Local Offices will do the work of supplying information on all matters relating to health insurance and they will no doubt be in touch with the Propaganda Branch for this purpose.

Apart from these permanent aspects of propaganda, in India, as soon as the Act is passed it may be necessary to take steps to educate the workers in regard to the provisions of the Act by lectures, printed literature, posters and handbills. Thus, by the time the scheme is actually put into operation, workers might not be found quite ignorant of what are their rights and duties. It may be mentioned here that in Japan for two years before the Act came into force the Bureau of Social Affairs organised lectures in industrial centres to familiarise the workers and employers with the principles of the Act.

J.—Actuarial and Statistical.

The Actuarial and Statistical Branch of the Fund will be acting as the watch-dog of the scheme, keeping itself fully acquainted with the trend of events on the statistical and financial side. Its work will be really a part of

the entire field of Social Insurance technique. Its responsibilities will no doubt be growing in the future with the adoption of other no less urgent measures of social insurance such as Invalidity, Maternity, Unemployment Insurance and Old Age and Widows' Pensions, etc., which may be brought together and consolidated in a general scheme of Social Insurance. The actuarial and financial technique and the underlying postulates of *social* insurance are so categorically different from those of *commercial* insurance, that the Board must, right from the beginning, have its own actuaries who have had special training in this line, and who can devote themselves on a whole-time basis to this subject.

The Actuarial and Statistical Branch will be obtaining its data from periodical returns sent in by the Offices of Centres and Sub-Centres. It will feel the pulse of the scheme in a very intimate manner from day to day. It will study the insurance experience of individual Centres and Sub-Centres, as also of particular Regions and Divisions with a view to statistical and actuarial control. If it finds that in a particular area the sickness experience is considerably more excessive than the average, it will bring this fact to the notice of the Commissioner of Health Insurance, who will institute immediate enquiries to find out the causes of such excess and take such steps as may be necessary to remove or mitigate the causes.

K.—Inspection.

Inspection of places where insurable workers are employed or are known to have been employed with a view to enforcing the provisions of the Act will be an important and indispensable feature of the scheme. The aversion of the Indian factory employer to allow inspection of this kind is well known and has been brought to light on more than one occasion, *but without unfettered inspection there are bound to be great loopholes in the scheme.* In this regard, we might adopt Section 165 of the *British National Health Insurance Act,* 1936, which empowers an inspector (a) " to enter at all reasonable times any premises or place.....where he has reasonable grounds for supposing that any employed contributors are employed ", (b) "to make such examination.....as may be necessary for ascertaining whether the provisions of this Act are complied with..... ", (c) " to examine every person whom he finds in any such premises..... " and (d) " to exercise such other powers as may be necessary for carrying this Act into effect." The occupier is required to produce all such information, including registers, books and cards, as the inspector may reasonably require. If any person wilfully delays or obstructs an inspector in the exercise of his legal powers, or fails to furnish information, or conceals or prevents any person from appearing before the inspector, he is liable on a summary conviction to a fine.

L.—Financial Aspects.

The financial aspects of the administrative machinery to bet set up can be visualised only very vaguely. It is difficult at this stage to forecast the precise number of Centres and Sub-Centres which may have to be formed. Nor can we say how many areas will have to be declared " Sparse Areas ". Detailed statistics in the form in which they would be required to decide this are not available, and cannot be collected unless the nucleus of the administrative machinery is established at the Centre and in the Regions, and this sets about actually demarcating the geographical limits of each industrial area for the purposes of health insurance. The " time-table " of the programme of health insurance, given in Chapter IX, Section I, *infra,* leaves enough time for this stage. Once the machinery is in full swing, the year-to-year estimates of expenditure will be a comparatively easy matter.

M. Recruiting and Training of Personnel

The art of health insurance administration is not a very technical subject. Nonetheless, it is highly essential that the right type of men are selected for appointment to the important administrative posts. In the beginning, of course, the Board will have to get on with whatever personnel is available. The Commissioner of Health Insurance must be a man who is acquainted with problems of Social Insurance and Indian Labour. In the beginning, at the time of launching the scheme, he will require the assistance of a foreign expert, but once the system gets into full swing, the Commissioner can be trusted to look after the administration by himself. For some of the other executive posts the Board can draw upon the personnel of the present Labour Departments of the Provincial Governments and the Government of India. In particular, men who have had experience of labour welfare and factory inspection may be appointed. As soon as possible, however, after the Board begins its operations, steps should be taken to draft courses and make arrangements for examinations of officers and staff under the aegis of the Federal Public Service Commission. The course might include subjects such as, Economics, in particular Industries and Labour, Labour Legislation and Welfare, General Principles of Insurance with particular reference to Social Insurance, Office Routine and Management, and Accountancy.

Chapter VII

THE MEDICAL ORGANIZATION

The problem of the medical organisation of industrial health insurance has been somewhat difficult to tackle. In the first place, not being a medical expert, I cannot profess to have an insight into the technical aspects of the subject nor a thorough knowledge of the modern trends in regard to medical care and medical administration. In formulating the following proposals, however, I have had the advantage of consultations with numerous medical experts in the country and representatives of medical associations and unions. I have also drawn upon the replies received from medical men to the Medical Questionnaire issued by me. Finally, before finalising these proposals, I have had the benefit of very thorough discussions with the Industrial Health Sub-Committee of the Health Survey and Development Committee. In addition to these, I have taken pains to go through the recent literature on the re-organisation of medical services. In particular, use has been made of the I.L.O. publications on Social Insurance (Series M. Nos. 4, 6, 8, 12, 13, 14, 15 and 18) and Report IV (1) and (2) of the International Labour Conference (Philadelphia), 26th Session, in which there are excellent monographs on income security, and medical care. Reference has also been made to Sir William Beveridge's Report, which advocates the establishment of a nation-wide medical service re-organised on a rational basis. I have also referred to relevant medical journals, including the *British Medical Journal*, which contain full reports of the findings of the British Medical Planning Commission and subsequent discussions in the medical fraternity in Britain. Finally, I have made some use of the British White Paper (Cmd. 6502, 1944) on the subject. The second difficulty which I have had to face is that on many matters of vital importance, medical opinion in the country is sharply divided. Especially on the question of "*panel*" versus "*salaried service*" there have been fundamental differences. This is not at all surprising. Even in Britain, a similar situation has arisen, The White Paper states : "One method would be to abandon entirely the present system, on which National Health Insurance has been based, and to substitute for it a system under which all doctors taking part would become the direct employees

of the State or of local authorities and would be remunerated by salary. As a problem of administration, there would be no insuperable difficulty in organising a scheme of this kind. But this is a highly controversial question, on which opinions are sharply divided. Many experienced and skilled doctors would be unwilling to take part in a service so conceived. They would hold that it infringed the second of the two principles just stated, and that if they became the salaried servants whether of the State or of local authorities, they would lose their professional freedom and be fettered in the exercise of their individual skill. Other doctors, with an equal right to be heard, would welcome a salaried service, believing that it would relieve them from business anxieties and enable them to devote themselves more freely to the practice of their profession, Lay opinion is similarly varied." Thirdly, the problem of industrial health insurance is complicated here by the fact that the technique of insurance is not easily applicable to the entire population as in other countries and by the fact that the Health Survey Committee of the Government of India are planning an all-India programme of medical services of a very comprehensive type. When I started preparing this scheme, no such programme was in sight, and consequently I had to consider the adaptation of the medical machinery to be erected here to the general programme.

Luckily, in India, the medical system has not been fossilised to the same extent as in some of the western countries and there are few, if any, vested interests here such as had to be reckoned with in Britain, when Mr. Lloyd George launched the National Health Insurance Bill in 1911. Fortunately, I believe, in this country it is possible for us to build on rational lines. It is a generally admitted fact, moreover, that the present medical equipment of the country leaves much to be desired both as regards quantity and quality.

It is clear that the establishment of a special medical machinery in industrial towns, catering for large sections of the urban population, will relieve the finances of Municipalities and Provincial Governments to a considerable extent. The provision of medical facilities, therefore, must not only be of financial interest to the Provincial and Local authorities concerned, but must presuppose the co-operation of such authorities also. Without that co-operation, it will be difficult, both financially and practically, particularly in the beginning, to provide the medical benefits which are the corner-stone of the whole scheme. It is for this reason that it is suggested here that the provision of medical facilities will be largely a concern of the Regional Authorities which are bound to be in closer touch, than the Central Administration of the Fund, with the Provincial Governments and their Medical Departments. Moreover, as Medicine and Public Health are largely a matter of provincial concern under the Constitution, and as they must be better aware than others of the difficulties and peculiarities of the areas falling within their jurisdiction, all medical matters must no doubt be chiefly decided in collaboration with the Provincial Authorities by the Regional Boards.

A. Indivisibility of the Scheme

Before I proceed to some of the more fundamental problems of medical organisation, I may refer here to the proposal seriously made by some that the administration of Cash Benefit should be separated from that of Medical Benefit so as to facilitate the complete absorption of the medical side of the scheme into the general health programme of the country. The proposal has had a history and has been put in two different forms. Reference has already been made in Chapter I, Section C, to the Royal Commission's proposal for splitting the two sides of health insurance by placing the responsibility for provision of medical benefit on the Government and that for cash benefit on the

employer. An opposite proposal has been made by some employers that they should be permitted to provide medical benefit, while the State should organise payment of cash benefit. In either of these forms, the proposal of separation of the two sides of the scheme appears to me undesirable and fraught with serious consequences.

My reasons why separation is undesirable are : firstly, that correct and reliable certification can best be secured under an undivided scheme ; secondly, that special efforts can be made only by a medical service which is part of the scheme to control and reduce sickness incidence in a manner which cannot be expected of a general medical service ; thirdly, that the problems of industrial medicine are somewhat peculiar and specialisation would be feasible by having a special service of medical men attached to health insurance ; and fourthly, that a service which caters specifically for industrial workers is likely to meet their requirements and redress their grievances much more satisfactorily than an organisation catering for the entire population in which the special problems of industrial labour can find little scope. Correct and honest certification is indeed the crux of the whole question on the financial side. Certification is the connecting link between cash benefit and medical benefit. That certification and, in consequence, also medical treatment, should be rigorously controlled by the Insurance Institution is an idea based upon the sound principle that he who pays the piper should call the tune. In this respect, divided responsibility and duplication of authorities—one certifying and the other paying out cash—must lead to financial confusion and administrative conflict. It might be mentioned here that in matters of certification, neither the general medical practitioner nor the service doctors have always been above board in the past. This has been largely due to the fact that the certifying doctor is not under the control of the authority required to grant leave, and ultimately laxity of certification has inflicted its burden inevitably upon the taxpayer, who has been seldom so vocal as to complain about it. After all, lax certification has been probably the cause of a fraction of the total waste caused in public services. Here, however, certification is all-in-all, a day-to-day affair, on which the entire fortunes of the scheme depend and which consequently cannot be lightly treated. The advantages to be obtained in respect of co-ordination, by separation of the medical benefit from the scheme, are insignificant as compared to the dangers of lax certification, and in any case the question of co-ordination of health activities can be tackled in a different manner, as suggested elsewhere in this Chapter. Apart from correct certification, the possibilities of minimising cash benefit liabilities arise from the direct administration of medical benefit under the aegis of the Insurance Institution : for cash benefit can be kept down by concentrating on (*a*) effective medical treatment, and (*b*) prevention through a direct approach to the various problems of industrial health, including nutrition, physical instruction, factory conditions, etc. The Insurance Institution has a direct and immediate interest in cutting down sickness incidence to the minimum possible such as a public authority working independently and for an enormous mass of population cannot be expected to have.

I am quite well aware that Sir William Beveridge has proposed in his monumental report a separation of medical treatment from the administration of cash benefits in Britain (*vide* his *Report*, pp. 48, and 158-9) : but the conditions in Britain are peculiar and, in any case, the experience of most other countries supports the principle that the two parts of health insurance should be under the administrative control of one and the same authority, whether directly or indirectly. The first compulsory sickness insurance law, the German Act of 1883, entrusted to the sickness funds the dual function of providing both for cash benefit and for medical attendance. This dual function has been retained in Germany and also adopted and confirmed by insurance laws in the Central

European countries. Even in Britain, where Mr. Lloyd George yielded to the clamour of the medical profession and set up insurance committees to administer medical benefit, leaving the approved societies to look after cash benefit, "there is only one insurance system of which the approved societies and insurance committees form part, although with different power." (Vide *Compulsory Sickness Insurance*, pp. 375-6). The Irish Free State appears to be one of the few countries, which has no medical benefit as part of its health insurance scheme. In that country, there is a fairly widespread system of dispensary medical treatment granted to the recipients, free of charge, at the expense of ratepayers. The Insurance Department (I am informed) has to pay the dispensary doctors rather extravagant fees for the medical certificates many of which are issued far too laxly. On the other hand, Northern Ireland which was similarly situated up to 15 years ago faced the problem, provided an insurance medical service, raising the health insurance contributions accordingly. Although there have been numerous cases of lax certification in Britain, on the whole, certification has been comparatively a reliable affair there. In proposing separation, therefore, it might be said that Sir William Beveridge had historical factors and traditions in view. The original separation was due to agitation on the part of the medical profession on which a panel system had been deeply engrafted, and which resented regimentation of any kind. Here in India, on the other hand, we have been accustomed to the principle of salaried service and the reasons which led the British authorities to establish Insurance Committees, are not, in any case, preponderant. Moreover, it must be remembered that in Britain under the Beveridge Plan, health services will be practically co-terminous with health insurance. That is not the case here. For a *limited scheme* like the present one, it is not only feasible but also desirable that the two parts of the scheme should be linked inseparably. In the special circumstances of India, and, especially in view of our utter lack of experience in regard to health insurance, I think safety lies in keeping the two parts together.

B. The Problem of Medical System.

The chief problem which arises in connection with the provision of medical benefits is as to what type of medical machinery would be suitable under the special circumstances arising in India. I have given considerable thought to this matter and the Medical Questionnaire I had issued has also been largely devoted to this question. There are two main types of medical machinery prevalent in foreign countries, viz., the Panel System and the Salaried Service System. The choice of the system for the purpose of health insurance has been a problem in almost all countries. As stated earlier, in the United Kingdom, it has recently arisen in acute form as an aftermath of the Beveridge Report and the Interim Report of the Medical Planning Committee. Private practitioners and the Government's medical advisers have arraigned themselves on opposite sides, the former championing the cause of the panel and the latter of service. The efforts of the Ministry of Health and Sir William Beveridge seem to be directed towards a rationalisation of the medical facilities available in the country. The Medical Planning Commission, representing the best elements of the British medical profession, has so far adopted a neutral attitude in this connection and its Interim Report is a clear indication of its desire to provoke thought and elicit opinion. Conditions in Britain are not on all fours with those in India. In Britain, the panel system is an established fact and has given rise to vested interests ; panel practices have been bought and sold, and reform involving dispossession of such practices must cause friction. Moreover, in Britain national health insurance accounts for a major proportion of the medical arrangements in the country. However, even before panel system was introduced in 1913, there existed well-established friendly societies

and a highly organised and fully equipped medical profession. These facts are absent in India. Allopathy is still in competition for a prime position as against other systems of medicine ; the Indian patient is habituated to change doctors, especially in cases of chronic diseases. The panel idea itself is quite a new one and the public, especially that section which will be covered by health insurance, is more familiar with treatment by medical service than by private practitioners. The latter class need not look with suspicion to the state medical service, only because the panel doctors in England regard it as something objectionable. In the first place, health insurance opens up a new and unexplored field for the medical profession and, therefore, there is no reason to imagine that the interests of the private practitioners would suffer much. Secondly, if a reform is desirable in itself and from the national viewpoint, that it would disturb vested interests would be a poor argument against it. Thirdly, to the extent that health insurance will employ a large number of medical men on a permanent basis, this will naturally relieve competition from the general field, to say nothing of the fact that it will provide bread and butter to thousands of struggling young men who after all are the confereres of the old-established private practitioners.

The most important argument in favour of the panel system is that it allows " free choice " to the insured to select his own doctor on the panel. However, this choice is more apparent than real. In actual practice, there is very little free choice for the poor, not only because of their inability to discriminate in their choice of medical treatment, but also because of the present inadequacy of medical relief. In a properly organised ' group practice ' under the health insurance scheme, the worker will be willing to take what he will get, because he will get the best. When medical treatment will be free and full, the question of " free choice " will not arise at all. Even under a panel system the so-called " free choice " is fettered by a number of limitations such as allopathic treatment and the financial and residential conditions. On the other hand, the panel system grants " free choice " to a medical practitioner to come on the panel, as also to select any locality for his practice.

Not only because of these defects in the panel system, but because of some intrinsic merits of the salaried service system, the latter is likely to be found more suitable in this country. First of all, this system is likely to prove more economical and administratively better controllable. The Board's own doctors working on a full-time basis under the supervision and control of the Central and Regional Authorities, are likely to be less liable to temptation in respect of false certification than panel doctors having private practices of their own to fall back upon at any time. A private practitioner, in order to get more cases and to be popular among the insured, may be lax in granting certificates, thereby lowering the morale of the medical profession and ultimately injuring the scheme. It may also happen that a medical practitioner, when successful, may drop out from the panel to start his own private practice, using the health insurance scheme merely as a stepping stone. It is likely that under the panel practice the insured workers may be attracted by a few successful doctors, thus throwing aside a large number of struggling young medical practitioners, whose services must by all means be drafted into this project. It is a curious paradox of the Indian medical profession that, while there is a great dearth of qualified medical men in the country in relation to the basic requirements of public health, large numbers of young doctors have to struggle for long years in making their livelihood. I think this paradox is explainable by the fact that although there is a great potential demand for doctors in this country, this demand is not effective for want of financial backing and owing to the poverty of the masses. The expansion of Social Insurance services must

partly provide this effective demand and it must not ignore those who are on the threshhold of their medical careers. Health Insurance must provide full-time employment to medical men on a large scale. Incidentally, it may be possible even to dovetail its requirements into those of post-war demobilisation of medical men, at present serving with the defence forces. When the war is over, the demobilised medical men from the defence services can be re-employed under the health insurance scheme.

However, the best feature of the salaried service system is the availability of all the advantages of *group practice*, facilitating speedy diagnosis and efficient treatment by various ancillary methods of modern medicine and surgery, which a single panel doctor working by himself may find difficult to adopt. An average medical practitioner scarcely possesses all the necessary equipment and without sufficient training it will not also be possible for him to cope up with all the industrial aspects of medicine. On the other hand, in group practice it is possible to employ specialists and to utilise costly medicines and apparatus in a cheaper way. Moreover, the fact that several doctors work together at big health centres is likely to keep their morale high. The principle of group practice is being increasingly favoured all over the world. Even those who favour the panel system evince an anxiety to move with the times by accepting the ideal of group practice. The British White Paper (Cmd. 6502) approvingly quotes the draft interim report of the Medical Planning Commission which observed : " The days when a doctor armed only with his stethoscope and his drugs could offer a fairly complete medical service are gone. He cannot be all-sufficient. For efficient work he must have at his disposal modern facilities for diagnosis and treatment, and often these cannot be provided by a private individual installed in a private surgery. He must also have easy and convenient access to consultant and specialist opinion, whether at hospital or elsewhere, and he must have opportunities of real collaboration with consultants. Facilities such as these are inadequate at the present time. There must also be close collaboration amongst local general practitioners themselves for their different interests and experience can be of value to each other. Although this need is recognised by practitioners, collaboration has not been developed as it should be." At the Annual Panel Conference in Britain held on November 12, 1942, (Cf. *British Medical Journal*, Supplement, December 5, 1942), a resolution was adopted in favour of group practice, but it was contended that even this should be on a voluntary basis. Similarly the Conference approved the general principle of " health centres," but objected to any compulsion in setting up such centres. In India also the supporters of the panel idea favour the establishment of group centres but object to both compulsion as well as State organization of these. It is, however, obvious that any form of health centres for group practice cannot be established on a uniform and efficient basis, unless they are organized by the State. In India, in particular, it is difficult to visualise the possibility of establishing " health centres " in any but a few industrial centres which satisfy our definition of a " compact area." In view of this it should be clear that the " health centre " idea cannot impinge upon the private practitioner to any great extent. Here it is also necessary to consider the suggestion of the private medical practitioners that they should be enabled to work at polyclinics in a group for difficult cases, instead of being allowed to ply their trade singly and separately. According to them, group practice is quite compatible with the private status of the doctor. Moreover, some of them are also prepared to remain partly on a salaried basis, so far as group practice is concerned. On the other hand, those who prefer the opposite idea state that group practice is more compatible with the whole-time salaried service and that the national policies of public health and medical care are likely to be better discharged through whole-time service men. To my mind, to allow group work to be per-

formed on a part-time basis or in any manner by private practitioners is a compromise with the existing private status of the medical profession. This compromise is naturally more popular and perhaps more necessary where the medical profession is both numerically broad-based and deeply rooted. In India, however, there are no vested interests in the shape of panel practices, purchased at substantial cost ; nor is the medical profession either numerically strong nor qualitatively adequate. In fact, future potentialities in regard to equipping the country with a larger quantity and better quality of medical service are so large, and the present position so insignificant, that I do not think that such a compromise is necessary from the standpoint of the country as a whole. What the existing medical practitioners urge is likely to be more in the interests of their own self-preservation than either in the interests of the country as a whole or of the future members of the medical profession. In shaping the future health policy of the country, the Government cannot afford to look to the interests of the few. They must visualise the entire problem from a larger and far-sighted standpoint. To take two examples, Russia and New Zealand have the most modern and most rationalized system of medical service and public health, unfettered by any sectional considerations. In Russia, for example, every form of medical benefit, preventive and curative, is granted to the whole population, free of charge and the cost is mainly borne by the State and the local authorities. (For details, vide *International Survey of Social Services,* 1933, I.L.O. Series M. No. 13, Vol. 1, p. 631). Within less than a decade, Russia has solved her medical and public health problems and has provided both qualitatively and quantitatively adequate medical services for her people. In Russia, for every 500 persons there is a doctor, while in India the proportion is 1 doctor to 9,000 persons. However, in the not very distant future, it is to be hoped, India will be able to achieve what Russia has done, if not at the same speed, at least by stages. It is no use, therefore, to erect any impediments to such an ideal development which is likely to suit everyone except perhaps some of the existing members of the medical profession.

It may be mentioned here that most of the replies to the Medical Questionnaire received from medical men favour, the establishment of a special salaried service rather than the panel system. Although this is also my view in general, I feel, that in practice some sort of amalgam of the two systems will be found necessary, mainly for financial reasons. The establishment of a health centre in any particular industrial area must be justified by the number of insured workers in that area. It is obvious that it may not be possible to establish group medicine at all centres, but that actually in smaller isolated centres a single doctor of the Fund may have to work in a dispensary with the assistance of a compounder and a nurse. However, even such a small medical establishment must be mainly supported by a sufficiently large number of contributions accruing in that centre. If any area does not contain a sufficiently large number of workers to warrant the establishment of a dispensary with even a minimum staff, but contains a sufficient number of workers to warrant the establishment of a small Insurance Sub-Office, it would obviously be more economical to entrust the medical work to private practitioners on the basis of the panel system. There may be some places, however, where even the establishment of an Insurance Sub-Office may not be a paying proposition. As may be seen in Chapter IX, such areas, called " Sparse Areas ", will be excluded from the operation of the scheme, subject to the provision of equivalent medical and sick-pay benefits by the employer.

Thus, the medical side of the scheme will have a triple basis :—

(i) *Health Centres,* providing group practice and polyclinical work for industrial centres which have a very large number of workers living in " compact areas," e.g., Bombay, Calcutta, Cawnpore, etc.

(ii) *Dispensaries* for smaller centres catering for a sufficient number of workers working in places somewhat remote from "compact areas" mentioned in (i) above. Such dispensaries may conveniently be established in the suburbs of big industrial towns as also in the smaller industrial towns. For specialist treatment or diagnosis, patients may be sent up to the Health Centres under certain conditions.

(iii) *Panel Centres* for still smaller industrial areas, where presumably the non-industrial population is large enough to facilitate the obtaining of private practitioners for this purpose.

It is difficult at this stage to indicate the exact number of the insured population in any centre, which will justify the establishment of any one of the three types of medical centres mentioned above. It will no doubt depend largely upon the number of insured workers whom one doctor can manage at any time, i.e., on the number of patients per day of all descriptions which he can attend to. If we know the number of insured workers in an area and also the average rate of sickness per annum per worker, we can arrive at the probable number of patients per day in that area. [Thus, if x represents the total number of insured workers and r the average number of days of sickness per annum per worker, then the number of patients per day will be on the average $=\frac{x.r}{365}$].

Incidentally, it may be stated here, that, we shall have both the systems operating side by side in their appropriate spheres and intelligent comparison would be afforded between the two as regards their relative merits.

Finally, the Health Insurance Act will have to provide for the preparation of regulations relating to panel practice along with other regulations relating to medical benefit.

C. Further Details Re : The Medical Machinery.

On some of the following matters, it is difficult for me to come to any definite decision. These are obviously matters to be decided by the Medical Committee of the Central Board of Health Insurance after consulting official and non-official opinion. Hence, I have made only tentative proposals.

(i) *The average number of insured workers in charge of each Medical Officer* :—As stated already, this will depend upon the number of patients per day of all descriptions whom a Medical Officer can conveniently treat. The distance factor will have also to be taken into consideration, especially where workers reside in villages round about an industrial town (e.g., Ahmedabad, Coimbatore, etc.). The Regional Authorities must be given directions regarding the general principles and must be left to work them out according to the requirements of different areas. The Regional Authorities will also consider the suitability of particular areas for establishing "health centres", "dispensaries", and "panel centres."

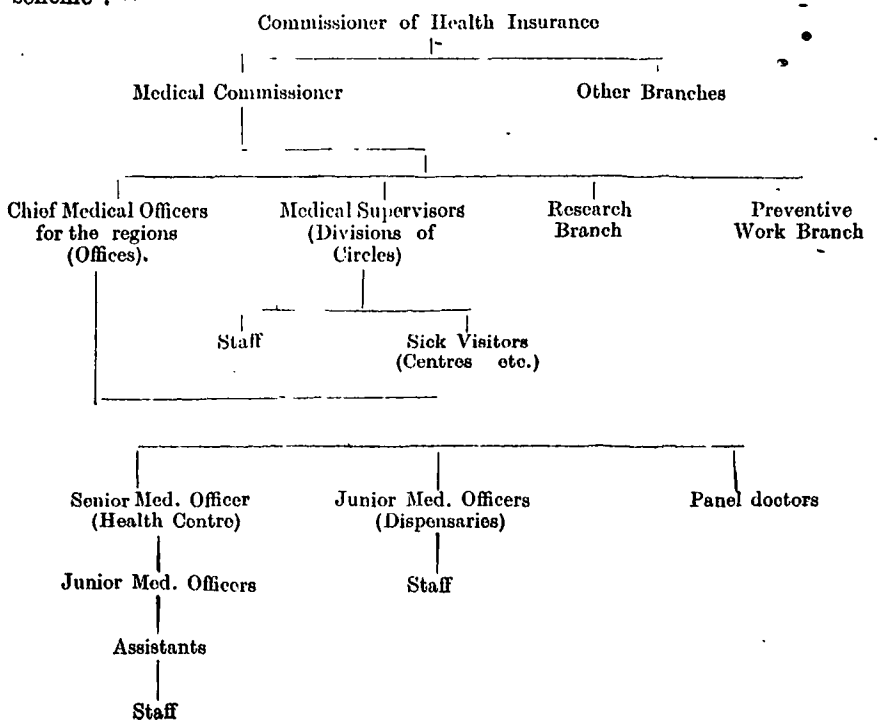
(ii) *Status and the scale of remuneration of Medical and Panel Doctors* :—The exact scale of remuneration which will attract the right type of medical men into Health Insurance Service will have to be determined. For obvious reasons, the scale must not be so niggardly as to encourage malpractices. Secondly, there must be three or four different grades according to the responsibilities and qualifications relevant to each post. For example, the juniormost officers may be in charge of the dispensaries in the smaller centres, and may also act as assistants to Senior Medical Officers at the health centres, and as far as possible no medical officer should be allowed to have independent

charge of a dispensary unless he has had some training as an assistant at a health centre. At the health centres we shall have comparatively senior men including specialists, who with the Regional Medical Officers and the Medical Commissioner at the Central Office, will belong to the superior cadre. Promotions and efficiency bars will be provided for.

The requisite qualifications for the above posts are also a matter for consideration. In my opinion, the qualifications should consist of not merely academical degrees but also practical experience at recognised hospitals or clinics, or in the capacity of a private practitioner for not less than a prescribed period of years. Preference, in particular, must be given to those doctors who have had training and experience in industrial medicine and surgery.

In addition to the staff requirements mentioned above, a separate service will be created which will be directly under the control of the Medical Commissioner and consist of (*a*) Medical Supervisors and (*b*) Sick Visitors. The functions of these officers have been described in Section H and I below. The Medical Supervisors will be of the same status as the Senior Medical Officers at health centres and will be itinerant officers working in Divisions of the Regions. The Sick Visitors will be either part-time or whole-time according to the requirements of each centre. These may be either medical men, or, where medical men are not available (as may be the case in very small centres), persons otherwise qualified for such work. The Medical Supervisors will control the Sick Visitors in their respective Divisions, as indicated in Sections H and I below. Moreover, as described in Sections K and N, there will be two branches of the Medical Commissioner's Office, concerned with Preventive Work, and Research in Industrial Medicine and Surgery, respectively.

The following Chart illustrates the medical organisation proposed under the scheme :—



As regards the scale of remuneration of Panel doctors there are several methods in vogue :—

(*a*) *The Capitation Method,* i.e., payment by reference either (i) to the number of insured persons on the doctor's list, or (ii) to the number of cases actually treated.

(*b*) *The Attendance Method,* i.e., payment according to the type and frequency of attendance given in each case. This payment will naturally differ from case to case.

(*c*) *The Fixed Remuneration Method,* i.e., payment for a specified period at a lump sum, in remuneration for part-time work.

(*d*) *Any combination* of the above three methods, or of their variations.

Of these methods the first method (i) i.e., payment by reference to the number of insured persons on the doctor's list, appears to be the simplest and most economical. Accordingly this is the method which will be adopted. How much remuneration per annum per insured worker should be given will be decided at a later stage. A maximum limit for the number of workers who can be allowed on the list of any one panel doctor must be laid down both in the interests of the worker and the doctor. Finally, the Health Insurance Authorities will have to issue detailed instructions to panel doctors in regard to their duties and rights and must indicate the penalties which will be imposed in the event of any breaches of such directions.

(iii) *Buildings and equipment of Health Centres and Dispensaries* :—In its initial stages, the Fund will not be able to incur the capital expenditure needed for the buildings and equipment of Health Centres and dispensaries. In the beginning, therefore, and perhaps in some cases, for all times, suitable arrangements will have to be made to avoid excessive capital expenditure. For example, in the bigger cities the Fund may be permitted to utilise the costlier type of equipment of existing hospitals, under agreement with local and provincial authorities, who will be benefited to a considerable extent by the financial relief provided by the Fund's hospitals and dispensaries. The Regional Authorities may also enter into agreements with Provincial Governments and Local bodies with a view to the construction of new buildings for health centres and dispensaries on the understanding that such buildings will remain the property of the latter. It should not, however, be difficult for the Fund itself to spend Rs. 1 or 2 crores in the very beginning from the Reserves, which are bound to accumulate on account of non-payment of partial benefit during the first two years, and also on account of the fact that, in the first six months of the operation of the Scheme, no medical benefit would be provided. This latter provision will also afford sufficient time to the Fund to make its arrangements for the provision of medical facilities in each area. As indicated n Chapter V, moreover, it should be open to the Fund to incur such capital expenditure out of loans specially raised for the purpose, repayable within specified periods.

(iv) *Medicines, Appliances and Inferior Staff.*—Apart from the capital expenditure indicated in the previous paragraph, the Fund will also have to incur recurring expenditure on account of medicines, appliances and inferior staff. The control of medical stores at the health centres and dispensaries should be vested in the Medical Commissioner, proper records being kept from time to time of the quantity, description and value of the stores, as is done at Government hospitals at present. Estimates of the probable expenditure on account of these and other incidental items cannot be worked out at present.

(v) *Provision of Hospital Treatment.*—As the fund cannot establish its own hospitals in the beginning, it will have to be permitted to enter into agreements with State, Local-fund and private-aided hospitals with a view to provision of actual treatment as and when funds permit (cf. Chapter IV. Section

C, *ante*). These agreements may provide for reservation of beds in hospitals and nursing homes and incidental treatment, the expenses being shared by the Fund on an agreed basis. Such agreements will, of course, be the concern of the Regional Boards in each circle, but they must be ratified by the Central Board. Further, these agreements, will be revised from time to time according to the needs of the Fund and other circumstances after due notice from either side.

When a patient is sent to a hospital, the Fund's doctor who has been initially in charge of the case, will do the certification work after satisfying himself on the basis of evidence available from the hospital, about the incapacity of the patient. If necessary, it may be provided in the regulations that the hospital doctor in charge of the case will also countersign. During hospitalisation, the patient will be under the discipline of the hospital only.

It is hoped that the health centres proposed in this scheme will in due course develop into large-scale hospitals. Initially, they will concern themselves with consultation, ambulatory and domiciliary treatment, as also research in industrial diseases, among other things. They will be equipped with sufficient apparatus but they will not be provided with buildings of their own. They will be housed in rented buildings, or, if possible, in municipal or Governmental buildings, by courtesy, at nominal rents. But it should be possible for the Fund at a later stage to erect full-fledged hospitals attached to the health centres, providing in-door treatment along the most modern lines to such persons as may be in need of it. It is expected that there will not be more than a few health centres (say, a dozen or two) throughout the whole country, at least in the beginning. It should not, therefore, be difficult for the Fund to set aside sufficient capital for construction purposes. At the health centres, treatment and diagnosis will also be available to patients sent up from outlying districts in difficult cases. It is hoped that such patients also would be able to obtain hospitalisation at the health centres, when they grow up into full-fledged units. In several South American countries, social insurance funds have begun to create a network of hospitals and clinics of their own in order to make up for the deficiencies in the national health equipment. There is no reason to imagine that there can be much difficulty in achieving the same object in India.

The specialist services to be provided at health centres can be best had by enabling the Fund to draw upon the existing body of private practitioners, amongst whom some first-rate men may be available. But obviously it will not be possible for the Fund to employ them on a whole-time basis. Nor, on the other hand, can they be asked to do honorary work as at present in some of the government hospitals, for the reason that the insured patients will not be allowed to bring them any private practice. Hence it may be necessary to obtain their services on a part-time basis.

(vi) *Supply of Drugs and Appliances in Panel Centres.*—In most of the countries having health insurance, the supply of drugs and appliances forms a necessary part of medical treatment, which is a right enjoyed by an insured person during the period of his incapacity. Under a salaried service system, the insurance institutions can supply most of the common drugs through their own stores or directly through their own dispensaries to the insured persons ; only for some drugs, which are exclusively sold by pharmacies, the insurance institution has to depend on the pharmacists. Under the panel system on the other hand, the general method that is followed is that the insured person is to obtain a prescription from the Panel doctor and to hand it over to a chemist to be dispensed. The insured person thus gets drugs and medicines free of charge, i.e., at the expense of the Fund, generally from the public pharmacies

or in some cases from the dispensing doctors, hospitals or insurance pharmacies. The medical practitioner is allowed to supply the drugs *only in exceptional circumstances,* such as the necessity of immediate application or administration of the drugs or inability due to distance or lack of communication on the part of the insured persons. It is essential for the sake of economy and proper treatment that dispensing work should be separated from that of treatment and that the former should be entrusted to licensed chemists' shops. Legislation or a special agreement between the insurance institution and the chemists (or pharmaceutical services) is essential for the free supply of prescribed medicines to the insured persons. If the doctors are allowed to do their own dispensing, there will be the danger of " over-prescription." Interesting cases are on record in foreign countries where business rackets have sprung up as a result of this. For instance, Dr. Armstrong (in her *The Health Insurance Doctor*, p. 232) mentions the case of a French doctor who ran a pharmaceutical concern of his own, and went on prescribing a patent medicine of his own for every sort of ailment ! Private practitioners are known to have financial interest in pharmaceutical works and chemists' shops and even in India this tendency widely prevails. In fact, this evil is one of the strongest arguments against the panel principle and needs to be kept in check, where panels have to be established in some areas for unavoidable reasons. Though the advantages of separating dispensing from prescription are many, it may be difficult to effect such a separation in this country. It is in regard to class III Areas, where presumably not only the industrial population but also medical facilities may be insufficient. We cannot expect that in such places there would be reliable chemists' and druggists' shops in existence. Here it may be difficult to entrust dispensing to chemists or druggists. Panel doctor himself may have to attend to both prescription and dispensing of medicines like any other general practitioner. In that case, rules similar to those in Part I of the first schedule to the *Medical Benefits Regulations* (1936) of Great Britain will have to be made.

D. Financial Aspects of the Medical Part of the Scheme.

It is obvious from the foregoing paragraphs that it is not possible at this stage to indicate the probable expenditure on account of the medical part of the scheme. But here it may be convenient to indicate in a summary form the various items which will have to be considered in this connection :—

(i) Salaries and allowances of Medical Officers, nurses and inferior staff.

(ii) Payment per head to be paid per insured worker to the Panel Doctors.

(iii) The distribution of localities according to density and number of the insured population amongst the three groups corresponding to health centres, dispensaries and panel centres.

(iv) The probable cost of medicines and appliances.

(v) Rent of buildings and cost of minor equipment.

(vi) Shared expenses in regard to hospital treatment, which the Fund may at its discretion provide through agreements with Provincial Governments, Local Boards, and private institutions, controlling existing hospitals.

(vii) Miscellaneous items not covered in (i) to (vi) above.

It should appear from the above details that it is difficult for anybody to say in advance what would be the total cost of medical benefit and administration. The distribution of localities, in particular, and the requirements of the each area will be known only when the Regional Authorities get down to the actual task of making arrangements for the medical facilities. Of course, some of the items, such as the number of insured workers in the charge of each medical

officer, the scale of remuneration of medical officers and panel doctors and the grades and cadres of the medical machinery, can be assessed in regard to their financial implications beforehand. But, on the whole, the financial picture is bound to remain incomplete. It may be mentioned here, in parenthesis, that even in the British scheme, as drafted by Sir William Beveridge (who has suggested a nation-wide re-organisation of the medical services), for want of adequate data and discussion, no financial estimate of medical machinery has been attempted. (See his *Report* p. 162). For the financial side of this reorganisation, Sir William Beveridge has proposed an addition to the contributions to meet the cost of preventive and curative treatment as may be adumbrated in the plan of medical re-organisation.

I have, therefore, the following suggestions to make in regard to the financial provision for the medical machinery and facilities. In the beginning, at least, and conceivably for some years thereafter, we should allot a definite proportion of the total annual receipts from contributions to the medical part of the scheme. Figures are given in Appendix XVI, showing the expenditure on medical benefit and machinery as a percentage of the total contributions in various countries. Of course, for various reasons stated below, these percentage figures have no hard-and-fast significance about them, but I believe they can roughly indicate what the probable magnitude of our medical expenditure should be or could be. It may be stated here that in most countries provision of medical facilities is common for sickness, invalidity, maternity, etc., while medical treatment of insured persons' families is also included in some cases. For these reasons, the percentages are likely to vary according to the nature of the scheme in each country, however if medical expenditure is excessive, so will be the contributions on account of other items of social insurance included in the schemes. Thus, as suggested in Chapter V *ante*, the percentages, or preferably an average of all the percentages available to us, may not be wide of the mark.

The Bombay Textile Labour Enquiry Committee (*Report*, p. 330) calculated the cost of free medical attendance on the basis of Rs. 3 per annum for each insured person, and in their opinion " this would cover all medical and surgical attendance at the homes of the insured when necessary, the issue of free medical certificates for health insurance purposes, and the maintenance of proper medical records." It should be noted that in the Bombay scheme, as in the present one, there was to be no waiting or qualifying period for medical attendance, and medical attendance was also to include free medicines and appliances. If we assume an insured population of 12 lakhs of workers, the total medical expenditure on this basis would amount to Rs. 36 lakhs only, or, about 14.3 per cent. of the total contributions collected in the year (on the basis of an average contribution of Rs. 1-12-0 per insured worker per month) This is nearly one-third of the percentage allowed for in the present scheme for medical benefit, viz, 42.5 per cent. of the total collections. On the other hand, in the course of an informal discussion, the Surgeon-General, Bombay, (Major General Candy) told me that in the City of Bombay, the cost of hospitalisation was about Rs. 3 per day, and for out-patients As. 8 per day. In view of the facts that, at the commencement, only out-door treatment was mainly feasible and that even later only a small percentage of cases would be normally requiring hospitalisation, we might take into consideration the out-patient rate only. According to that rate, Rs. 108 lakhs would suffice for an average rate of sickness of 18 days per annum per worker, for 12 lakhs of workers. This works out at about 43 per cent. of the probable total collections (viz., Rs. 252 lakhs per annum on the basis of an average contribution per worker of Rs 1-12-0 per month). I am inclined to think, however, that the estimate of the Surgeon-General, Bombay, is somewhat on the high side, and probably true of a costly

place like Bombay City. It cannot be equally true of all the scattered centres of health insurance. Moreover, in the case of health insurance, it may be expected that the medical officers would be paying special attention to the rules regarding economical administration of medical and pharmaceutical benefits, such as are enjoined in almost all countries having health insurance schemes (vide *The Economical Administration of Health Insurance Benefits.* I.L.O. Series M. No. 15, for details.) It will be one of the first tasks of the health insurance authorities to lay down rules regarding economical prescribing and economical dispensing, as well as regarding the control and supervision of prescription and dispensing. It is not suggested that the present provincial administration of medicine and public health is lacking in care and economy, but, in the very nature of the case, health insurance is likely to be more economical in its outlook. On the whole, therefore, the conclusion appears to be that the financial provision made for medical benefit, which is *three times* as much as the Bombay estimate and nearly enough according to the estimate of the Surgeon-General, Bombay, would be more than adequate to the purpose.

The total allocation for the medical part of the scheme may be distributed amongst the Regions (whose constitution is suggested in Chapter VI) *pro rata,* according to the number of insured workers in each Region. As the Regional Authorities will be mainly entrusted with the work of making arrangements for the provision of medical facilities, it would be in the fitness of things if they are also empowered to provide the finance for such arrangements in the most suitable manner. Of course, the Regional Boards will be fully responsible to the Central Board, which will have to scrutinize all proposals in this regard and which will also have to give detailed directions to the Regional Boards for the provision and maintenance of adequate standards of medical facilities and other relevant matters.

Incidentally, the distribution of the funds thus allocated amongst the Regions will also to some extent, meet the wishes of those who are anxious to establish some sort of *quid pro quo* between the contributions and benefits in different areas. From figures collected in regard to sickness incidence by me and figures independently available, it appears that the rates of sickness in the Regions are likely to vary. Thus, automatically the provision of medical benefits in those areas which have a higher sickness experience will not burden other areas which have a lower experience.

E.—Rights and Duties of Insured Persons.

An insured person will be entitled :—

(a) To receive, free of cost, such medical treatment and attendance as can be expected from a doctor of ordinary professional competence and skill as also hospital and specialist treatment, to the extent this is provided.

(b) To receive, free of cost, proper and sufficient drugs and prescribed appliances either from the doctor or a pharmacist.

(c) To receive treatment, notwithstanding his inability to produce his Medical Card, subject to the payment of a deposit.

(d) To receive treatment from an insurance doctor in the case of accidents or other sudden emergencies.

(e) To be visited by the doctor if his condition so requires.

(f) To receive, free of cost, medical certificates for Health Insurance purposes.

(g) To report any failure on the part of the doctor to give proper and sufficient treatment, to the Competent Authority for investigation.

An insured person in receipt of Medical Benefit must comply with the following rules :—

(a) He must produce his Medical Card, if required by the doctor to do so.

(b) He must obey the instructions of the doctor attending him.

(c) He must, whenever his condition permits, attend at the surgery on the days and at the times appointed by the doctor.

(d) He must not conduct himself in a manner which is likely to retard his recovery.

(e) He must not make unreasonable demands upon his doctor.

(f) He must not summon the doctor to visit him at night between specified hours, except in cases of serious emergency.

(g) He must, when his condition requires a home visit, give notice to the doctor, if the circumstances of the case permit, before say 10 A.M. on the day on which the visit is required.

F.—Certification and Medical Reference.

The Medical Officer, or the panel doctor as the case may be, will be required to issue a medical certificate if the worker so desires (i.e., if he expects to obtain cash benefit under the rules). There will be three kinds of certificates to be issued as the occasion demands it, *viz.*, (a) First Certificate, (b) Intermediate Certificate, and (c) Final Certificate. The forms of certificates in each case will be as provided by the Fund. The first Certificate will be given as soon as examination reveals that the worker has become totally incapable of work is in, in the doctor's opinion, entitled to cash benefit on that ground. The Intermediate Certificate or Certificates will be issued, *if* necessary, at stated intervals, say once a week. if the worker is found still incapable of work. The Final Certificate will be issued as soon as the doctor finds that the worker will be fit to resume work within 3 days of such examination. The Final Certificate must in no case be issued after the insured person has actually resumed work. Further particulars of the forms and manner of certification will have to be decided at a later stage.

As indicated in Chapter VI again, medical certificates are a *prima-facie* proof, but they will not be accepted by the Office, necessarily as final proof of sickness. The Fund's Office, on the basis of independent evidence obtained through other sources, such as Sick Visitors, employers, and other informers from amongst the insured workers themselves, or any other official or non-official source, may decide to refer any particular case to a Medical Referee. This Medical Referee will be the local medical officer of the town, belonging to the Provincial Medical Service. He will be paid on the basis of the number of cases thus referred to him. If the Medical Referee reports that the case does not satisfy the legal definition of "sickness.", the Fund's Office may decide to withhold the cash benefit. Disputes relating to this and other medical matters will be dealt with in Chapter VIII.

G.—Nature of Treatment.

The treatment which a doctor is required to give to an insured person shall consist of :—

(a) All proper and necessary medical services other than those involving the application of special skill and experience of a kind which general practitioners as a class cannot reasonably be expected to possess.

(b) The provision of such drugs and prescribed appliances as are needed.

(c) Vaccination (or other preventive treatment) within the competence of the medical officer, if such is considered to be in the best interest of the patient.

(d) Such minor surgical treatment as falls within the competence of the medical officer concerned.

(e) The issue of medical certificates for Health Insurance purposes.

H.—Sick Visitation.

The Medical Commissioner will appoint Sick Visitor or Visitors in each area for the purpose of visiting the insured workers who are incapable of work, and are, or may become, entitled to benefit. Such Visitors shall report to the Fund's Office on such matters as the Fund's Office may determine. The Medical Commissioner will issue detailed instructions to the Sick Visitors, with the approval of the Commissioner of Health Insurance. The Medical Supervisors (see Section I below) will supervise the carrying out of such instructions by Sick Visitors in their respective Divisions and will be the connecting links between the Medical Commissioner and the Sick Visitors.

An insured woman worker shall not be visited otherwise than by a woman visitor.

I.—Medical Supervision.

The medical Commissioner will also appoint Medical Supervisors for supervising the medical organisation and facilities in each Division of a Region. The functions of a Medical Supervisor will be as follows :—

(a) The maintenance of uniform standards of medical facilities as laid down by the Regional Board of the Region to which they have been assigned ;

(b) Inspection of drugs, appliances and other stores and examination of records relating to the same ;

(c) Hearing of all complaints relating to medical matters in the area under their control, such complaints and the steps taken being in every case brought to the notice of the Regional Medical Authorities, the Local Committees, the Fund's Offices, etc., as the relevance of the occasion may demand ;

(d) Control of Sick Visitors as indicated in the previous Section ;

(e) To see that the intention of the Health Insurance Act in regard to all medical matters is properly carried out ;

(f) To see that in " Sparse Areas " *(vide* Chapter IX) the employers provide medical facilities according to standards laid down under the Act.

The Medical Supervisors would be directly responsible to the Medical Commissioner and through him to the Central Board of Health Insurance. They will be, in effect, doing the policing and intelligence work on the medical side.

J.—Post-Medical Rehabilitation.

" Rehabilitation " as Sir W. Beveridge defines it (See his *Report*, pp. 162-3) " is a continuous process by which disabled persons should be transferred from the state of being incapable under full medical care to the state of being producers and earners." This process requires close co-operation between the Health Insurance Department and Employment Exchanges. During this process of rehabilitation, the worker may be assisted by the Fund's Office to get employment either with his old employer or with a new employer through Employment Exchanges. " Rehabilitation benefit ", whether in cash or in kind, may not be given at this stage, but may be placed as an item on the future programme of Health Insurance.

K.—Preventive Treatment and Activities.

It must be realised that much of the sickness amongst workers is of an avoidable nature. Preventive treatment and activities are likely to be of great *financial value* to the Fund. In every branch of insurance, it has come to be recognised as a very important principle that prevention is better than cure. In life, accident, fire and marine insurances, the development of preventive activities is the most significant fact as ultimately it results in the shrinking of risk and low cost of operation later. Efforts, therefore, must be made in health insurance as well to develop this preventive aspect. Preventive work would largely consist of two kinds :—

(a) Public sanitation, inoculation, slum clearance, housing, ventilation, nutrition, better factory standards, etc., and

(b) Individual sanitation, care of health, exercise, physical education, etc.

Obviously, a great deal of co-operation between the workers and the Fund, as also with Municipal and Public Health Authorities will be necessary. The worker will have to be educated and the sanitary conscience of the employer aroused, if any permanent results in the reduction of the rate of sickness are to be expected. It may be mentioned here that the purpose of Health Insurance is not merely cure but maintenance of the health and efficiency of workers at their maximum, so as to reap the maximum harvest of production for the industry concerned and the nation as a whole. It is being realised everywhere that sickness is a liability and a deduction from the national income. Health insurance, therefore, must attack at the very root of the causes which bring about disease and ill-health, and not merely cure the symptoms. Such fell diseases, as tuberculosis, malaria, kala-azar, typhoid, plague, small-pox, cholera, etc., which not only take a large annual toll of life, but also breed disease and ill-health where they do not kill, are preventable to a large extent by organised measures. The Public Health Departments of the Central and Provincial Governments are already doing valuable work within the limited means at their disposal. The Health Insurance Fund must co-operate with these Authorities and root out the causes of disease and pestilence in *industrial* areas which will be partly under its care. Moreover, under the Factories Act, the conditions of work in factories and their surroundings have been carefully laid down. But in spite of fairly efficient administration of the Act, there still persist great lacunae in factory sanitation, to which the Health Insurance Authorities will have to devote their attention.

L.—Medical Treatment of Women Workers.

An important question to be decided is as to whether there should be any separate arrangement for the treatment of women patients by lady doctors. At such health centres as may be located in industrial areas having large numbers of female workers in factories it may be feasible to appoint lady doctors to look after such cases. Similarly, at the dispensaries in small Centres there will be one nurse at least. However, whenever medical examination of women workers by male doctors is necessary, it must take place in the presence of either a lady doctor or a nurse (where there is no lady doctor) or of another woman worker known to the patient (where there is neither a lady doctor nor nurse, as in the case of panel centres).

In addition to the medical benefits available to male patients, the women workers may be given, free pre-natal and post-natal treatment, and gynaecological treatment. Obviously, so long as Maternity Benefit is outside the scope of health insurance, the Fund will not be able to shoulder the burden of maternity

treatment and there will be some incongruity in these arrangements.. But it is hoped that in the not very distant future it will be possible to bring Maternity Benefit under health insurance.

M.—Non-Allopathic Treatment.

I do not think that it would be possible for the health insurance administration to provide any non-allopathic treatment. This does not imply any value-judgment upon the efficacy or virtue of non-allopathic systems such as the Ayurvedic, Unani, Naturopathic, Homeopathic and others, some of which are undoubtely popular in this country. It is very difficult to visualise any method of co-ordinating the various systems of medicines and harmonising them into the system of certification which is the crux of health insurance. Proverbially even doctors are known to differ, but if Vaids, Hakims, Naturopaths, Homeopaths and quacks of all descriptions are thrown in, there will be a veritable pandemonium ! It will open the door to controversies, into which even communalism and faddism might be imported, while the insured person might play one system against another in trying to obtain cash benefit. What is more, there will be a very costly multiplication of administrative agencies for providing treatment, for maintaining registers of various kinds, for supplying medical stores and keeping accounts for each different system. The inclusion of different systems is positively contrary to the principle of salaried service ; if, on the other hand, the Panel principle is adopted, the possibilities of speculative transfers of cases from one system to another with a view to obtaining cash benefits will complicate matters and make the whole scheme unwieldy. It will be easily admitted that allopathy is the best organised and legally the best regulated system in India as in other countries. Limitation of medical treatment to allopathy will lead to simplicity and efficient adminstration. The essence of the matter is that it is only possible to select any one system of medicine for purposes of health insurance, and naturally, in view of its recognised position, allopathy is best suited for the purpose. It is not true to say that the worker is almost averse to taking allopathic treatment, as can be easily proved from the overcrowding in the free hospitals and dispensaries situated in industrial areas. His aversion, if any, arises from the fact that, where it is not free, it tends to be more costly than non-allopathic treatment, and also from the fact that he is more accustomed owing to his rural antecedents to non-allopathic treatment. To some extent, he also feels, and perhaps rightly, that there is too much *bandobast* in some of the public hospitals. Under the present scheme, however, every care will be taken to see that the worker gets a decent treatment in the hospitals and dispensaries, and, moreover, the medical attendence and treatment will be free and expeditious. If, in spite of this, any worker prefers non-allopathic treatment, he will be free to take such treatment, but it will be impossible to pay him any cash benefit, in view of the difficulties of certification. Finally, it may be stated that nowhere else in the world, does health insurance make provision for any kind of non-allopathic systems even though they are widely prevalent and popular outside health insurance. I realise that there is a wide demand in the country for recognition of indigenous systems of medicine. This demand is legitimate and I have no doubt that it is being and will be conceded by the Governments concerned to a greater and greater extent in their public health policies. But, as is clear, this can be best done where health facilities are based upon the principle of social *assistance* rather than that of social *insurance*. I have no doubt that for the vast majority of people in India the problems of public health will have to be tackled on the principle of *assistance*. There will, therefore, be enough scope for the governments concerned to patronise indigenous systems of medicines for this purpose.

N.—Medical Research.

A point of considerable importance has been raised by some medical men replying to the Medical Questionnaire, *viz.*, the question of research in industrial medicine and surgery. There is no doubt that to a very considerable extent the diseases with which Health Insurance in industries will have to come to grips will be industrial diseases, and it is essential that research in those diseases should be carried out and their causes investigated and removed. Like prevention, research will be a matter of vital concern to the insurance doctor, who should from time to time not only study important cases, but pass on the information collected to the Research Branch of the Central Board, where the data will be scientifically analysed and used.

In addition to research of this kind, it would be profitable to conduct a complete survey of each area to be covered by the Act, detailing the factors likely to influence health and hygiene and the success of action taken, if any, to deal with them. This work may be regulated and carried out in accordance with the principles suggested by the Hygiene Committee of the League of Nations for the calculation of health indices, etc. Similarly, the health conditions and public assistance services available in each region should be examined ; the medical equipment and apparatuses, hospital beds, etc., in so far as they can be made available to health insurance should be recorded ; and a planned and economical scheme of preventive propaganda and establishment of proper medical facilities should be framed.

O.—Existing Medical Facilities provided by the Employers.

A very controversial question is as to what should be done about the existing medical facilities of varying importance, provided by the employers themselves. During my discussions with the respresentatives of the employers, I was told that the Scheme should be erected in such a way as to cause the least possible disturbance to the existing medical facilities. This question was also considered at the *Ministerial Labour Conferences* (See *Proceedings of the Second Conference*, pp. 70-71, *Proceedings of the Third Conference*, p. 57) and it was feared that " the introduction of the Sickness Insurance Scheme might undermine the good work already done by large industrial undertakings."

I have discussed this question in detail in Appendix XVIII. Here I may briefly state my conclusions. Four main alternatives were considered by me : (i) to permit the present system to continue but to allow the employer's doctor to certify sickness and treat the workers, compensation being granted to the employer for the medical expenses, and cash benefit being paid out of health insurance funds ; (ii) to take over the existing facilities, including staff and equipment ; (iii) to ignore the employer's facilities altogether, leaving him to decide their future as he thinks fit ; and (iv) to extend, in a selective manner, the same privileges as are to be granted to Government concerns, under the heading " scheduled exceptions," to such private concerns. Of these, I favour the last course, for reasons stated in the Appendix, but " exception " here will have to be hedged in with certain conditions, so as to leave no loopholes for evasion. The conditions are : (*a*) firstly, the employer must make a written application making out a case for exception on the ground that the facilities provided by him are no less favourable than those provided under the Act ; (*b*) Secondly, there must be a registered agreement between workers and the employer accepting the arrangement, provided that the denouncement of such an agreement or a threat of such denouncement must not be used as a counter in any strike negotiations, and that if the Central Board is satisfied that consent of workers is frivolously withheld, this condition might be waived ; (*c*) thirdly the competent authority must satisfy itself that the facts are as stated

in the employer's application and that the agreement with workers is genuine ; (*d*) fourthly, there should be a representative Committee of Supervision entrusted with the task of ensuring that the agreement is being fully enforced and reporting to the competent authority from time to time ; (*e*) fifthly, the " exception " should be subject to periodical revision ; (*f*) sixthly, Medical Supervisors should be required to visit the excepted concern with a view to getting first-hand information about the working of the " exception " ; and (*g*) finally, detailed regulations should be laid down under the Act to cover this subject.

In some cases, however, it might be possible for the health insurance authorities to take over, by purchase, the employer's facilities for medical treatment, *i.e.*, if the employer is agreeable. The exact compensation which should be given to the employer might be determined by negotiation, or failing this, by arbitration. Generally speaking, the entire facilities including staff, equipment, appliances and medicines, and buildings, might be taken over. But as mentioned in Appendix XVIII, there are certain serious difficulties in adopting this course.

Broadly speaking, the facilities provided by most employers at present are farcically inadequate. The Factories Act empowers the Provincial Government to frame rules " requiring managers of factories to maintain stores of first-aid appliances and provide for their proper custody," (Sec. 32), and rules have in fact been framed in the Provinces. Yet the question of intra-factory medical treatment is not subject to proper regulation. I think, it is quite essential that, side by side, with the provision of health insurance on an *extra-factory basis*, the existing law relating to *intra-factory* hygiene and health should be further improved.

Chapter VIII.

THE JUDICIAL MACHINERY.

In this Chapter, I shall now describe the types of disputes and offences which are likely to arise and the kind of judicial machinery that may be erected to deal with them conveniently at each stage.

A.—Disputes.

Disputes may arise on several scores and between several parties. Care has been taken in the drafting of the scheme to minimise the chances of disputes as also of offences. However, even in the most perfect scheme, disputes are likely to arise, while the chances of fraud and bribery are also bound to be ever present. In this Section are described the main types of disputes which will have to be provided for. The main types may be classified under four heads : (i) Disputes regarding Scope, (ii) disputes regarding Contributions, (iii) disputes regarding Benefits, and (iv) disputes regarding Administration of the Insurance Institutions.

(i) *Disputes regarding Scope.*—Disputes regarding the undertakings liable to compulsory Insurance are not, generally speaking, very common. In foreign countries disputes arise because of the difficulty of drawing a line of demarcation between " industry " and " commerce " and the difficulty in connection with industrial undertakings attached to large farms. Sometimes, as in Japan, the " degree of unhealthiness of an undertaking " decides the inclusion or otherwise of the concern in the scheme ; and this gives rise to considerable discussion and disputes. Under the proposed scheme for India there could be little cause for disputes on this score because the scheme covers undertakings which come under the Indian Factories Act. This Act determines which undertakings are to be included and this has not to be specially determined. (See also Chapter II, Section A.).

A more common cause of disputes is regarding the nature and duration of employment and the wages of the worker. So far as the nature of employment is concerned all the " workers " coming under the Factories Act will automatically come under this scheme as well. Special provision would be made for " contract labour ", so that occasions for disputes are minimised. As the worker generally is required to mention his age fairly early, i.e., at the time of taking up any insurable employment after the enforcement of this scheme, the incentive for wrong statement would probably be not there. So disputes on account of age are not likely to be many.

(ii) *Disputes regarding Contribution.*—The scheme also reduces the causes of disputes regarding contributions considerably. Disputes on this account arise between the employer and the Fund regarding the method of calculating wages and, where there are several wage-categories, the wage-category in which the worker is to be placed. The provision that only the " basic wage " is to be taken into account for the purposes of this scheme, would largely minimise disputes regarding the method of calculating wages. Further, the simple provision of the scheme that the employer, in the first instance, will have to pay to the Fund a contribution of Rs. 1-4-0 with respect to every worker removes the basis of any dispute between him and the Fund. Regarding the differences between the employer and the worker, it is to be stated that the trouble mostly arises in cases where contributions are granted. According to the proposed scheme this is not to be the case. So far as the time-workers are concerned, the wages paid would be entered in the Service Card at the time the payment is made ; and this will decide whether the worker belongs to A class, B class or C class. There could be no cause of dispute here. But the same cannot perhaps be said regarding piece-wage earners. Payment of the worker's contribution would fall due on the first day of the month, but the wages which he actually earns would be known only at the end of the month. It might be that a worker supposed to belong to A class turns out to be a B class worker ; or *vice-versa*. In such cases, adjustments would be called for between the employer and the worker, at the end of each month. This might give rise to some disputes. However, in the case of piece-wage workers, the determination of the standard rate will be according to each type of workers. If a worker belongs to a particular type, his contribution will be fixed automatically, whatever be his actual earnings during any month. If there are any disputes in this connection, they will arise mainly about the Local Committee's decisions, regarding fixation of piece rates. This kind of disputes, however, can be mitigated by (a) issuing detailed directions regarding calculation of piece rates on a time basis, and (b) having a suitable machinery for actual calculations.

(iii) *Disputes regarding Benefits.*—Benefits are probably the most fruitful cause of disputes. These disputes may relate to :—

1. Conditions for obtaining benefit.
2. Cash Benefit.
3. Medical Benefit.

Disputes regarding claims to cash benefits are common. Conditions to be satisfied for the establishment of a claim are : (i) Statement of sickness by patient ; (ii) Medical Certificate ; (iii) Waiting period ; and (iv) Past contributions.

There are sometimes disputes regarding medical certification and calculation of the waiting period. The cases of contradictory medical reports are extremely rare. But there might be difficulties in applying " linking-up " rules, at least in the beginning. The conditions regarding past service and contributions may also give rise to misunderstandings and disputes. There

are sometimes disputes in connection with cash benefit and additional benefits, chiefly the latter. But the present scheme fixes the rates and duration of benefit in a precise and simple manner. There are also likely to be complaints regarding delay in payment of benefits and the scheme must try to reduce this cause of disputes as much as possible. Medical benefit again gives rise to several causes of disputes. The disputes here generally relate to the type and quality of medical benefit. Cash benefit can be fixed with precision and no qualitative difference can be made in administrating it. But medical benefits, in spite of precise definition, have, of necessity, to be left to the discretion of Medical Officers and complaints are bound to arise in relation to the kind and nature of treatment.

(iv) *Disputes concerning the Administration of the Insurance Institution.*—Most of the disputes have already been covered in the above discussion. There may be disputes between the Fund and employers regarding affiliation of insured persons and payment of contributions ; between the Fund and insured persons regarding benefits ; and between the Fund and Panel doctors regarding the discharge of general duties and proper dispensing of medicines. All these have been generally covered in the foregoing paragraphs. But a more important subject which requires consideration is " departmental " disputes. There may be disputes regarding the election or appointment of members of the various bodies, as also regarding the convocation of meetings. There might be friction between the various bodies regarding the proper scope of their rights and duties, though occasions for such troubles have been sought to be minimised in the scheme. For instance, Regional Boards may complain about what to them might appear to be an irregularity in the allocation of funds. Provincial Governments might not feel satisfied with the manner in which members are appointed on the Regional Boards. There are bound to be reasonable disputes with regard to the medical machinery and the medical supervisory body. There might be disputes about the Medical Supervisor or Sick Visitor having exceeded his powers ; regarding differences about certification ; regarding accuracy of reports of Medical Officers, Medical Supervisors or Sick Visitors which may be contested even by the insured. Many of these disputes of a purely departmental nature would be referred to and decided by the Chairman of the Central Board or his nominee in consultation with the Commissioner of Health Insurance and would not be referred to subordinate legal bodies.

B.—Offences and Penalties.

The more important offences which can be committed in relation to health insurance may be conveniently divided into seven classes. Their nature and suggested penalties are discussed below :—

(i) *Employment.*—Employers may commit several offences in this regard. They may fail to carry out or may only incompletely carry out their obligation to compile and keep lists of workers and maintain such other records as the health insurance authorities ask them to do. In such cases they would be liable to a fine not exceeding Rs. 500 for each case of infringement. They may even keep false records, when they should be liable to a fine not exceeding Rs. 1,000, and/or simple imprisonment not exceeding six months.

They may also commit offences in regard to the submission of returns, and communicating such information as is required by the health insurance authorities, *e.g.*, about the engagement and dismissal of insurable employers, the wages payable to them, etc. They may fail to furnish information within the prescribed time, when they would be liable to a fine not exceeding Rs. 500. In case they refuse to furnish information, they should be liable to a maximum fine of Rs. 1,000. Again, they may submit false information. In such a case

they should be liable to a fine not exceeding Rs. 1,000 or simple imprisonment for not more than six months.

Offences may also arise in connection with the deduction of the workers' contribution from their wages. The employers may deduct from workers' wages amounts higher than the legal rates or they might make certain deductions of this nature from the wages of uninsurable workers. In such cases they should be liable to a fine of from Rs. 250 to Rs. 500. In case any employer does not deduct from the wages of the workers their share of the contribution, he must himself pay the contribution and will not be entitled to reimbursement if the worker has left his service or if 3 months have expired since the payment in question.

If an employer fails to provide equivalent benefits in " Sparse Areas ", he will be liable to a fine of Rs. 1,000 for the first month of delay, Rs. 2,000 for the second month of delay and the fine will rise by Rs. 500 each month thereafter.

(ii) *Payment of Contributions* :—The next group of offences relates itself to payment of contributions. Any employer who fails to affix the contribution stamps should be liable to a fine of 100 times the amount of the stamps which he has omitted to affix ; the fine may be doubled in case of repetition of offence. Moreover, any employer who fails or neglects to pay a contribution which he is required to pay on account of a worker employed by him, or who does not conform in respect of that worker with the requirements of the regulations concerning the payment and collection of contributions (provided that such omission prevents the worker or any person acting in his name from receiving in whole or in part the benefits to which he would have been entitled) would be liable to be sued summarily by the worker who has suffered by the omission, negligence or refusal of the employer as for a civil debt, for a sum equal to the amount of the monetary benefits forfeited and also for a sum equal to the amount of the expenses incurred through the fact that the employer was not entitled to medical assistance. If any employer enters into an illegal agreement with his workers and thus evades the payment of contribution, both parties would be liable to a fine equivalent to 100 times the contributions thus withheld. Any covenant between employer and worker, under which the worker agrees to the employer's deducting from his wages the employer's share of the contribution, shall be void and of no effect.

(iii) *Obstructions* :—The third group of offences is about obstructions to the enforcement of the Act. Any person who obstructs the supervision of the enforcement of the Act by refusing information required, refusing to submit documents required by the Act, or preventing the questioning of persons summoned by an inspector would be liable to a fine not exceeding Rs. 100. A fine not exceeding Rs. 100, without prejudice to further prosecution under another law or regulation, would be imposed on employers or their representatives who knowingly interfere with the total or partial enforcement of the Act to the detriment of the insured persons or restrict the freedom of the latter to hold any official positions.

(iv) *Illicit Benefits* :—This group of offences has mainly to do with insured persons who try to get benefits to which they are not entitled. (*a*) Double insurance is prohibited, *i.e.*, the worker while drawing cash benefit under this scheme will not be entitled to receive further cash benefit under any other schemes. A worker disregarding this would be liable to pay double the amount of the sum thus illegitimately received to the Fund. (*b*) If a worker commits any fraud (*e.g.*, mis-statement of age) to obtain illicit benefits to which he is not entitled he would be liable to a fine not exceeding Rs. 50 which may be commuted into one month's simple imprisonment on non-realization. (*c*) Insured persons guilty of malingering would be liable to a fine up

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to a sum, equivalent to ten times the daily cash benefit, and, in serious cases, to expulsion from the scheme. Workers who neglect medical instructions or who fail to observe regulations laid down for insured persons during sickness would be liable to a fine of a maximum sum equal to 10 times the daily cash benefit.

(v) *Fraud and Falsification of Documents* :—Forging or falsification of stamps would be punishable under the Indian Stamps Act. Falsification of insurance forms and accounts has been covered in the above discussion without prejudice to the general criminal law. Any person who carries on without due authorisation, trade in insurance cards, or books or used insurance stamps would be liable on summary conviction to a fine not exceeding Rs. 1,000, or imprisonment for a period not exceeding six months, or both.

(vi) *Irregularities in Administration* :—Members, officials or employees of the Fund violating professional secrecy would be liable to a fine up to Rs. 500 or imprisonment for 3 months or both. Keeping of false accounts or wilfully supressing insurance accounts which should be submitted for audit would be punishable by a fine not exceeding Rs. 1,000, or imprisonment for a period not exceeding 6 months, or both. Granting assistance to an insured worker knowing that the latter is not entitled to it, would be punishable by a fine up to Rs. 500, or imprisonment for a period not exceeding 3 months, or both. Delinquent officials shall be liable to dismissal. Prosecution in ordinary courts may be undertaken against persons who have embezzled the funds of the health insurance organisation.

(vii) *False Certification* :—Doctors must carefully understand what is meant by " sickness " and in case of doubt refer the matter to a Medical Supervisor. It should be remembered that no precise definition to explain " incapacity to work " can be devised, and that the description offered in Chapter IV, Section B, can only be of general assistance. As the Fund cannot verify each and every case of certification, it must view with grave concern any kind of irregularity in the issue of certificates. It is not only the case of false certification (*i.e.*, certifying sickness where no sickness was present) which comes under irregularities, but the following are the general cases of irregularity suggested by practice in the United Kingdom : (*a*) certifying that a patient was examined on a given date when in fact there had been no such examination, the patient not having even been seen ; (*b*) ante-dating or post-dating a certificate ; (*c*) the signing of blank forms, subsequently to be filled up by a dispenser or some other person. In fact, any wilful infringement of the Rules in regard to certification may be punishable with fine, imprisonment, or removal or suspension from the Medical Register, according to the nature of the offence.

C.—Machinery for Dealing with Disputes, Complaints and Offences.

The main principle that has been adopted here in erecting the legal machinery is to use as far as possible the regular administrative machinery so as to provide cheap, speedy and efficient relief. Appellate and superior judicial bodies are suggested for difficult or important matters.

All disputes, complaints and offences will be, in the first instance, referred to the Local Committee, the Regional Board and the Central Board according to the relevance of the matter. Whenever any case involves consideration of any medical questions, the Medical Supervisor or his representative (*e.g.*, a Sick Visitor) must be present. These Committees and Boards may from time to time appoint Sub-Committees to deal with particular cases. Cases will be classified according to their nature and the Sub-Committees may handle the cases in a batch at different sittings. The Committees and Boards will decide

all questions in the first instance. It must be noted, however, that their jurisdiction will be confined to disputes and offences which are peculiar to Health Insurance. The offences and disputes commonly arising in relation to Health Insurance will be enumerated in the Act itself or in the Regulations framed thereunder. If, however, there are disputes and offences of the ordinary kind which are not governed by the Act or Regulations, they will be dealt with in the ordinary courts of law (*e.g.*, misappropriation of funds, thefts, burglaries, assaults, etc., will be dealt with in the ordinary courts of law). If there is any doubt as to whether any particular question does or does not fall within the competence of the judicial machinery erected here, such doubts will be settled by the Chairman of the Central Board, or by his nominee.

All medical disputes and complaints must be referred, in the first instance, to the Local Committees. If this Committee is satisfied that the fault lies with the doctor or his staff, it must bring this to the notice of the Medical Supervisor or his representatives. The Medical Supervisor must report the action taken to the Committee and to Medical Commissioner.

If the Committees or Boards are doubtful as regards the interpretation of any legal provision, they may make a reference to the Special Courts suggested below. If, on the other hand, doubts arise regarding any matters not covered by the Act or the Regulations, they may make reference to the Commissioner of Health Insurance, who will place the issues, together with his own recommendations, before the Chairman of the Central Board and the latter will decide.

If any party to a dispute or an accused feels that there has been a grave miscarriage of justice or that wrong procedure was adopted by a Committee or a Board, he can prefer an appeal to the Special Court. Similarly, on a question of law appeal may lie with the Special Court.

Special Courts :—There will be three or four Special Courts for the whole country, and for the purpose of determining their territorial jurisdiction, Regions may have to be grouped together. Each Court will consist of three judicial officers of high legal qualifications who are conversant with industrial and labour laws (one of them being the Chairman). In addition to these three judges, there will be one or two assessors appointed by the Deputy Commissioner of the Region concerned on an *ad hoc* basis to assist the judges on any technical, medical, industrial or actuarial matters.

I am not in a position to decide whether the judiciary should be set up under the Act as part of the scheme, in view of the fact that the scheme will be controlled by a Statutory Corporation. If constitutional procedure prevents this, the judiciary might be set up independently by the Government of India. The alternative is to allow insurance matters to be decided by the Provincial courts of law, but I am not in favour of this.

The Court will in every case convey their decisions in regard to questions of law to the Commissioner of health insurance for his information. If the latter finds that there is any lack of uniformity between the decisions of two or more of the Special Courts, he will make his recommendations to the Chairman who will give a definite ruling so as to secure uniformity. Any Special Court, which having taken notice of an existing decision of another Special Court is inclined to differ from the latter, should make a prior reference to the Commissioner of health insurance who will obtain a ruling from the Chairman in a similar manner.

If the Court feels that any particular matter has not been covered or has been inadequately covered by the Act or Regulations, it may make a reference, as stated earlier in the case of Committees and Boards, to the Commissioner of health insurance in a like manner.

D.—Decision of Questions and Doubtful Points.

Special regulations will have to be framed for dealing with the problem of decisions on doubtful questions. We may adopt the British model of *Decision of Questions Regulations, 1937* (*England and Wales*), which provides for the determination of any doubtful questions regarding all matters relevant to Health Insurance. The Minister appoints a person to hear the application and to report his findings, according to procedure laid down, to the Minister who may determine the question. Questions may be referred by not only parties to the health insurance but also by the Courts entrusted with settlement of disputes.

Where the Act or the Regulations are precise and clearly understood, the Court entrusted with the settlement of disputes will be fully qualified to interpret the Act and the Regulations. But the Court cannot make the law itself in regard to matters regarding which no or inadequate provision has been made. It is in regard to such matters that reference to the Competent Authority will be necessary.

E.—Miscellaneous.

(i) There will be only a nominal court fee for filing suits in the first instance, but appeals to Special Courts would require a stamp duty according to the law of the land in this regard.

(ii) Appointments of legal officials will be made by the Chairman of the Central Board or a person empowered by him to make such appointments.

(iii) The legal bodies will in suitable cases try to make the parties to a dispute agreeable to arbitration and might be empowered to enforce the decision to a reasonable degree.

Chapter IX.

MISCELLANEOUS

In this Chapter, I propose to deal with certain important miscellaneous matters which could not be conveniently considered earlier.

A.—State Contribution to Health Insurance.

Although the Labour Ministers' Conferences decided some time back that the State should not contribute to health insurance, and although subsequently (as stated in Chapter I) the Government of India and the Provincial Governments agreed to the provision of a mere guarantee, I feel that during the intervening period, fundamental changes have taken place all over the world in the outlook of Governments towards the question of the financing of social security measures. I have, therefore, considered this matter from various angles and have come to the conclusion that financial participation by the State (including both the Government of India and the Provincial Governments) would be an eminently desirable feature of the scheme. I have threshed out the factual side of this question also in Appendix XIX, so as not to encumber the main report ; but here, the main reasons for my view might be briefly stated :—

(1.) In the first place, the general proposition that the State should bear its due share of responsibility in regard to Social Security *as a whole* is one which

needs little argument. The United Nations' declarations of peace aims, including the Atlantic Charter and its off-shoots have made this a fundamental plank of the post-war programmes of social amelioration. The series of Conventions and Recommendations on the various branches of social insurance, which have been adopted by the International Labour Conference, since 1925 (culminating in the recent ones proposed by the Philadelphia Session), the social security plans of Great Britain (based on the Beveridge Report) and Canada (the plan prepared by Dr. L. C. Marsh), the Wagner-Murray-Dingell Bill and the National Resources Planning Board's proposals in the United States, and scores of national plans in various other countries (including, in particular, South American countries), amply indicate the modern trend in regard to the part that the State is expected to play in Social Security measures. In most of the civilised countries and even in backward countries, the State is assuming to an evergrowing extent financial responsibility in this connection. In India, moreover, in view of the programme of post-war reconstruction, there are certain special reasons for State participation in finance.

(2) Turning from the general question of social security financing to the special one of health insurance finance, the liability of the State might be considered under three heads : (a) medical benefit, (b) cash benefit, and (c) administration. Side by side, there arises also the question whether the State should contribute to a scheme which is confined to a section of the population, under any of these three heads. I must straightaway admit that I have not, anywhere in the literature bearing upon this subject, come across any *reasoned* attempt to decide the allocation of liability arising from health insurance amongst the three parties to social security, viz., the worker, the employer and the State. Even in regard to workmen's compensation (for industrial accident and disease), for which the employer alone was held responsible up till now, the trend appears to be in favour of allocating some share of the responsibility to social insurance funds supported by tripartite contributions (vide *Beveridge Report*, pp. 35-48). Moreover, from Appendix XX, which gives information about the respective shares of the three parties in health insurance, finance, and Appendix XXI, which contains a conspectus of schemes of voluntary and compulsory insurance all over the world, it would appear that the practice in this regard is not decisive. In some cases, health insurance is supported by employers and workers, in others by employers alone, and in still others by all the three parties. The Sickness Insurance Conventions of the I. L. O. (1927, Art. 7) lays down that employers and workers shall contribute, but adds that it is open to national laws to decide as to a financial contribution by the public authority. The I. L. O. Draft Convention, 1944 (Income Security Art. 73) states that " The cost of benefits, including the cost of administration, should be distributed among insured persons, employers and *tax-payers* in such a way as to be equitable to insured persons individually, to avoid hardship to insured persons of small means, and to cause the least disturbance to production." Under Art. 79, it further requires that the residual costs of benefits should be met from taxation, and also defines the elements of residual costs. The Draft Convention (Medical Care), Arts. 78 and 79, states that " Persons whose income does not exceed the subsistence level should not be required to pay an insurance contribution. Equitable contributions should be paid by the public authority on their behalf ; provided that, in the case of employed persons such contributions may be paid wholly or partly by their employers," and that " The cost of medical care service not covered by contributions should be borne by taxpayers." Health Insurance is a measure which combines income security (during spells of sickness) with provision of medical care and here, therefore, the liability of the State on both counts appears to be implicit. Let us now come to each of the three items of cost mentioned above, viz., medical benefit, cash benefit, and administration.

(a) As regards *medical benefit*, the State in India has already assumed liability in regard to the provision of free medical facilities to the public. But at present the medical facilities are unfortunately inadequate in proportion to the requirements of the population. When the new health programme of the post-war period comes, it may be expected that the State will assume its full responsibility in this regard. Whatever be the future prospects of that health programme, however, it is clear that provision of medical benefit is mainly the responsibility of the State and has been admitted as such here. In view of this, the State can legitimately be required to contribute to the cost of medical benefit in a measure which is equally applicable to the rest of the public which falls outside the insurance scheme. To the extent that the medical facilities available under the scheme are in excess of those available to the general public, perhaps, the employer and the worker may be required to pay. I am not sure that as the scheme stands, the medical facilities are thus in excess, but in view of the fact that special facilities might be required in respect of industrial disease and accident, a small margin of excess may possibly arise. The question may also be raised why there should be any separate provision of medical facilities for industrial workers. The answer to this question, I think, is to be found in the case for segregation made out throughout this Report in view of the special conditions of this section of the population.

(b) The State's liability in respect of *cash benefit* is less obvious as well as less conclusive. It would appear, however, that the liability is inherent in the case of the low-paid workers, who are not in a position to pay the whole or who are in a position to pay only a part of the actuarial contribution, as also in that of persons entering insurance above the minimum age (which, under the budgetary system, falls illegitimately upon the younger sections of the insured group).

(c) In the case of *administrative expenses*, again, it is fair that the State should bear a portion, in view of the fact that it would be controlling, directly and indirectly, the insurance organisation, otherwise Government's right to interfere or participate in the internal administration of the scheme becomes open to question, and the general sovereignty of the State has to be invoked to answer the objection.

(d) We might also consider the question here whether the State would be justified in making contributions from the general revenues for the benefit of a particular section of the population. This argument has been raised over and over again against State contribution to *industrial health insurance*. I am afraid this argument is based upon a somewhat orthodox view of the nature of public finance. Public finance, as any text-book writer can tell us, consists of a series of operations which inflict burdens or confer benefits upon *particular sections* of the population. There is hardly any measure, whether of taxation or expenditure which affects the entire population *en masse*. The budgets of Governments are full of instances showing that taxes have been levied upon particular classes of consumers, particular industries, and particular categories of producers, and that grants-in-aid and subsidies have been paid to particular sections and institutions (sectional, communal and what not) for particular purposes. Considered from this angle, any budget is a patch-work of nicely balanced measures. As regards the welfare function of the State, moreover, it is hardly to be expected that the same stock formula or measure can be devised for the entire population. The State is expected to fill in gaps here and gaps there in different ways as expediency dictates. It may spend the public funds on industrial workers in a particular way, but on the agricultural masses in quite a different way. There is no fixed rule about this. The fact that the State

contributes to an insurance scheme designed to help industrial workers does not debar it from spending an even greater amount upon agricultural workers by way of social assistance. Social security measures are meant for the poorer sections of the public, just as taxation is meant for the richer sections, because it is here that the social structure is full of strains and faults. Likewise, health measures, on which the State is prepared to spend, singles out a particular group, viz., the weak and diseased individuals. The only point to which careful attention is to be given is that the expenditure on any particular section of population or for any particular purpose is not so *excessive* as to create disproportionateness and lack of perspective in the State budget. As will be apparent from what follows, the total sums involved in connection with the State contribution to health insurance are likely to be an extremely small proportion of the total budget of the country or of any province. In view of these considerations, I do not think there is any logical or practical difficulty in the State contributing to a scheme designed for a section of population.

That brings us to the question of the probable extent of the State's liability. The Government of India comes into the picture in a triple capacity : (a) as the employer of workers in Government-owned concerns ; (b) as the Government of the centrally administered areas, in which capacity it is on par with the Provincial Governments ; and (c) as the Central Government. Likewise, the Provincial Governments have a double capacity : (a) as employers of workers in concerns owned by them, and (b) as Provincial Governments. In both cases, we may leave out (a) , i.e., their capacity as employer, because here contribution in any case will have to be paid, unless " exception " is claimed and granted under provisions suggested in Chapter II, Section B. Let us consider the remaining two capacities. In regard to (b), it is obvious that provision of health facilities is under the Government of India Act the primary responsibility of Provinces and Administrations of Centrally Administered Areas. So, if any contribution is due on account of para. 2 (a) above, both the Government of India, and the Provincial Governments will have to pay, in this second capacity. The question which remains is as regards the position of the Central Government. Here it may be useful to remember that " health insurance " is an item in the Concurrent List of Legislation, and that although it might be easy to pass on financial responsibility for medical benefit to Provinces under the provincial item of medical aid, this is a measure primarily for *health insurance*, and, moreover, this is going to be enforced under a Central Act. Moreover, it is proposed in the present scheme, and it is an inevitable feature of the scheme also, that the Government of India, as well as the Provincial Governments, should share in the internal administration of the scheme. In view of this, I think it would be difficult for the Government of India to put it across to the Provinces, that this is merely a provincial responsibility. Moreover, the Government of India's responsibility, under para. 2 (b) and (c) above, still remains.

I shall now turn to the size of the State contribution. If reference is made to Chapter V, Section B, it will appear that the worker's own contribution answers to 12 days' cash benefit in the year, in view of the principle that what the worker contributes per month he will get as cash benefit per day. I do not expect that the " net rate " of sickness incidence, i.e., the claims rate, or number of days for which cash benefit has to be actually paid, is likely to be very much in excess of 12 days per worker per annum. This means that the worker's own contribution will substantially finance the cash benefit. Thus, it is clear that the employer's contribution of Rs. 1-4-0 will mainly correspond to the cost of medical benefit and administration. Of course, this does not imply that the employer necessarily pays for medical benefit ; we might as well look at it from an opposite angle and say that the employer pays for cash benefit plus cost of administration, while worker pays for medical benefit. The essence of the

matter is that nearabout 42.5 per cent. of the total cost, which is allotted to medical benefit, is borne by employer and worker, when presumably their contributions should largely concentrate on cash benefit. If, therefore, the State's responsibility arises on account of medical benefit (to the extent that this is on par with the medical benefit available to the general public) as also partly on account of cash benefit and administration, it is clear that the State as a whole should shoulder its appropriate burden in these three respects.

Assuming an average total contribution of Rs. 1-12-0 per worker, the annual collections for 12 lakhs of workers amount to Rs. 252 lakhs. Of this amount, as indicated in Chapter V, Section B, 42.5 per cent., will be allocated to Medical Benefit, 12.5 per cent. to Administration, 40 per cent. to Cash Benefit, and 5 per cent. to reserves. I think it is a fair proposal that a half of the medical costs, a half of the administrative expenses, and one-tenth of the cash benefit should be borne by the State. This brings the total percentage cost to be borne by the State to 31.5 per cent. This works out at about 8.4 annas per worker (31.5 per cent. of Rs. 1-12-0), or roughly 8 annas. Of the 31.5 per cent., the cost of medical benefit is obviously a Provincial liability (seeing that it will be relieving their finances substantially), while a part of the administrative and cash-benefit costs also may fairly be assigned to them. Accordingly, I think the ratio of the Central to the Provincial share may be put at 1 : 3. If this ratio is reasonable (as I feel it to be), it follows that the Government of India will have to contribute per worker As. 2 per month, and the Provinces (all together) As. 6 per month. Assuming an insurable population of 12 lakhs of workers, therefore, the Government of India's annual contribution to the health insurance funds for the whole of India will be Rs. 18 lakhs (excluding its small liability on account of its capacity as the Government of the Centrally Administered Areas). The annual contribution of all the Provinces taken together will be, on the same basis, Rs. 54 lakhs, and this will be divided *pro rata* among them, on the basis of the number of insured workers in each.

That brings us to the question of adjusting the employer's and worker's contributions. In the absence of a State contribution, I had to suggest a somewhat higher contribution from the employer than from the worker, in view of the latter's inferior ability to pay. If, therefore, a State contribution is going to be available, it is legitimate that this should give greater relief to the employer than to the worker. Accordingly, I propose that, out of the As. 8, As. 6 should be devoted to a reduction of the employer's contribution and As. 2 to a reduction of the worker's contribution. Thus, the scheme of contributions will be as under :—

Contributing party.	Class A.	Class B.	Class C.
	Rs. A. P.	Rs. A. P.	Rs. A. P.
State	0 8 0	0 8 0	0 8 0
Employer	0 14 0	0 14 0	0 14 0
Worker	0 10 0	0 6 0	0 2 0
Total ..	2 0 0	1 12 0	1 8 0

It may be added that this would leave the scheme of *benefits* undisturbed, and the workers will be entitled to the same scale of benefits as proposed in Chapter IV, Section C (d).

B.—Maternity Benefit.

In Appendix XXII, I have discussed this question at length, and reference may also be made to Appendices XXIII, XXIV, and XXV, giving certain factual and statistical information relating to maternity benefit legislation in Provinces and States. Here I propose only to state my broad conclusions.

In India, maternity benefit legislation has preceded health insurance and naturally the question of applying the insurance principle to maternity could not be given full consideration although the Royal Commission on Labour clearly indicated that maternity benefit should "form an integral part" of "any general scheme of sickness insurance," and also suggested that in the event of any general scheme of sickness insurance being adopted, maternity benefits should be incorporated therein (*Report*, p. 264). There is no all-India legislation on maternity benefit, but only a series of measures adopted by Provinces and States in some cases. It does not appear, however, that piecemeal legislation in Provinces and States has been successful. The main defects of the legislation are as follows : (1) In the first place, the legislation has been neither quite uniform nor universal, so that there are gaps here and there, which are not fair to the workers ; (2) secondly, only cash benefit is given at present, and there is no provision for medical benefit, except of a very superficial kind in one or two places ; and (3) thirdly, it is clear that evasion is widely prevalent, in spite of provisions aimed at its prevention. Ignorance and weakness of the women workers are taken advantage of in many places, and there is reason to suppose that, on the whole, the employment of women has been discouraged. In view of these facts, and in view of the close interconnection (medically) between health insurance and maternity, I feel there will be considerable advantages in having a scheme of insurance for maternity benefit on an all-India basis and in affiliating it to the present scheme. This would enable us to avoid the anomaly which must arise very soon from the position that the female worker would be taking care of herself during maternity (under the present arrangement) and would have to be looked after by health insurance centres both before and after the period covered by the maternity laws. It will also lead to other facilities which are fully described in Appendix XXII. On the other hand, the possible objections to amalgamation are likely to be few, and I think these can be easily met.

In Appendix XXII, I have given particulars of a tentative maternity benefit scheme, complete with maternity cash benefit and provisions for maternity treatment. The financial estimate for this is in the neighbourhood of Rs. 10 lakhs per annum. I have proposed that this amount should be raised by making a small addition to the employer's contribution to the health insurance funds, so as to leave the present liability of the employer undisturbed. I may also add that in framing the final scheme, an attempt may have to be made to make it conform to the provisions of the Havana Maternity Code, 1939.

C.—Gratuity and Bonus.

There will be no gratuity paid to any worker, or to his successors, on his withdrawal from the Fund for any reason whatsoever. Health insurance is quite unlike other forms of insurance, in that the risk of sickness is concurrent with contributions paid and an insured person has no reserve value in respect of his insurance unless of course, we adopt the individual capitalization method, which is never done in health insurance. If a worker does not fall sick, that does not mean that he did not have the benefit of insurance, because he has been fully insured against the risk of such sickness. Although, however, there is no case for paying a gratuity or bonus to the healthy worker (as the non-claim worker pays for the sickness of the sick worker), it may be possible to provide that a worker who has had a good record of contributions and health should get a free "protective period" for cash and medical benefits, if, and, when he leaves the industry.

D.—Strikes and Lock-outs.

In regard to strikes and lock-outs, I propose that we should adopt the British solution, *viz.*, that periods of strikes and lock-outs should be regarded

as periods of unemployment and no contribution should be paid either by the employer or by the worker, according to the rule that "no contribution is payable in respect of any week during which no remuneration is paid and no services are rendered." As the relevant period for contribution here will be one month, if a strike period is less than the calendar month during which the strike takes place, obviously contributions will be payable by and for those workers who were employed during the working period of the month. Such contributions will be taken into consideration like any other contributions in providing benefits. If, however, the strike period exceeds any calendar month, there will be no contribution payable either by the employer or the worker. This fact, again, will be taken into consideration in assessing any worker's right to benefits.

E.—Contract Labour.

All contract labour will be included under the scope of health insurance, and the Principal Employer will be held responsible for the contributions and not the Intermediate Employer (*viz.*, the Contractor or Sub-Contractor). This is in accordance with the British practice. (See *Collection of Contributions Regulations*, 1938, Rule 34, "Intermediate Employers".) The Principal Employer shall deduct the worker's contribution from any sums payable to the Intermediate Employer, who in his turn can recover it from the worker.

It is impossible to adopt the practice suggested in the Workmen's Compensation Act, Section 12, under which the worker has the option of suing either the occupier or the contractor. The reasons are quite obvious. In the first place, the Workmen's Compensation Act provisions imply only an occasional and contingent compensation, while here it is a day-to-day and permanent question regarding payment of the contributions which are not a single block payment. Secondly, the affairs of the Fund cannot permit any uncertainty or option in regard to payment, and there is no possibility of the Fund constantly resorting to a law court for exercising its option. Thirdly, the contractor or sub-contractor is generally an elusive person, and very often both contractor and his workers may disappear from the scene and it would be difficult to tackle them. However, certain features of the Workmen's Compensation Act will be incorporated in the present scheme as can be seen below.

There has been a considerable amount of case law and discussions in the United Kingdom in this regard, the burden of which appears to be that the real test is "which employer retains the power of controlling the worker" and that is a *question of fact* to be decided by reference to the circumstances of each case by the Minister, against whose decision appeal may lie with a judge of the High Court on any *question of law only*.

If contract labour is excluded, there will be a constant tendency on the part of employers to engage contract labour only, even for regular processes, and conceivably on fictitious contracts. In certain industries like Jute and Cotton Textiles (Ahmedabad), contract labour is often employed on a large scale in regular manufacturing processes.

The following principles will be adopted in this connection :—

(i) Is the work part of a manufacturing process ? If so, the worker will be covered and the principal employer will be liable, unless of course the worker is *principally* employed under the contractor himself and the latter is already paying contributions in respect of the worker.

(ii) Is the work connected with or incidental to manufacturing process, and if so, is it perennial in character ? If the answer is "yes," the worker

is covered and the principal employer is liable, subject to the same conditions as above.

(iii) Is the work of a casual or non-recurrent nature ? If so, the worker may be excluded.

(iv) The contract must be made " in the course of or for the purposes of the employers' trade or business."

(v) The work must be done on, in or about the premises on which the principal has undertaken or usually undertakes to execute the work, or which are otherwise under his control or management.

(vi) The kinds of " contract labour " which will be covered will also be generally indicated in the schedule referred to in Chapter II, Section E.

F.—Sparse Areas.

As stated earlier, it will be impossible, for financial and practical reasons, to include " Sparse Areas " in the scheme. A natural consequence of such exclusion on the ground of sparseness might be to encourage the establishment of new factories in sparse areas, and even if this does not happen it will place industrialists in such areas in a position of advantage as compared to those in others. This would not only defeat the purpose of the scheme but also cause discontent among employers. For sparse areas, therefore, special provisions and regulations will be necessary under which the State must enforce the establishment of standards of medical facilities and sick pay, on the whole not less favourable than those available in the Region concerned, at the expense of the employer and the State (to the extent that the latter participates financially in the scheme). Secondly, it will be necessary to enquire from time to time whether the Regulations are being observed or not by the employers in such areas. This work will be done partly by the Inspectors (so far as sick pay is concerned) and partly by Medical Supervisors (so far as medical facilities are concerned). Thirdly, statistics of employment, and Service Cards will have to be maintained even by these employers for all classes of workers employed and all information required by the Fund will have to be supplied by them. If at any time it is found that any such area has ceased to be a sparse area, by reason of its expansion, the Fund must proceed to establish its own Centre or Sub-Centre in that area. At that time it would be open to the employer to transfer his medical facilities to the Fund, the compensation to be given by the Fund being decided by negotiation and if negotiation fails, by arbitration.

G.—Holidays with Pay.

In most countries, including Great Britain, holidays with pay subsist side by side with health insurance. It is not a plausible argument that there is no need of holidays with pay once a scheme for health insurance is started, as the purposes of the two measures are entirely separate : whereas sickness benefits are available only during spells of sickness, holidays with pay are meant for relaxation or other purposes *during periods of health* and for sick and healthy alike. In fact, in the absence of holidays with pay, there will be a general tendency on the part of workers to utilise health insurance for obtaining surreptitious holidays, and the absenteeism, which holidays with pay are intended to remedy, will be debited to health insurance. Not only this, but in the absence of holidays the ordinary rate of sickness is also likely to be higher than if holidays were given. The proper course would, therefore, be to provide both measures simultaneously. The Holidays with Pay Bill, which is being circulated for eliciting views, therefore, must be regarded as being unprejudiced by the present scheme.

During holidays or leave with pay, both the employer and the worker will pay their respective contributions as usual, as during such periods remunera-

tion is paid by the employer to the worker. But if any worker falls " sick " during such periods, he will be entitled to medical benefit only and not cash benefit. This is so for two reasons, *viz.*, (i) that if cash benefit is paid during such periods, there will be a constant tendency on the part of workers to malinger as the total income would be more than the ordinary income, and (ii) that even otherwise the worker will be quite able to support himself and his family during " holidays with pay."

H.—Workmen's Compensation and Damages.

When an insured worker has received or is entitled to receive any compensation or damages under the Workmen's Compensation Act or under any other law, in respect of any injury or disease, the following provisions will be necessary :—

(i) No cash benefit will be payable to the worker, unless this is greater than the compensation or damages due or obtained, in which case only the difference will be paid. If the cash benefit is already paid, it will be recovered, to the extent that it can be, out of the compensation or damages. (*Cf.* British Act, 1936, Sec. 51.) For example, A. B., who is qualified for Rs. 15 as cash benefit meets with an accident and is awarded Rs. 10 as compensation. Cash benefit is only payable at Rs. 5. If compensation were Rs. 15 or more, no cash benefit will be payable.

(ii) If a worker appears to the Fund's Office to be entitled to compensation or damages, but he unreasonably refuses to take proceedings to enforce his claim, the Office may either withhold payment of cash benefit, or may itself take proceedings in the worker's name. If the proceedings are successful, the costs of litigation incurred by the Fund will be borne by the worker as explained in (iv) below, but if they are unsuccessful, they will be borne by the Fund.

(iii) The Fund can make an advance of benefit to the worker pending the settlement of any claim for compensation or damages, and recover the money from the employer, after due notice, out of the compensation to be paid by producing receipts of such advances, provided further that it will be always open to the Fund to recover any advance of benefit by deductions from any benefits to which the worker may subsequently become liable or by any other lawful manner (*e.g.*, by instalments, as a first charge on the wages to be paid to him by the employer).

(iv) The doctrine of *subrogation* governing property insurance may find its application to health insurance. This doctrine states that when an insurance company has indemnified the insured in regard to a loss or damage under an insurance policy, the former steps into the shoes of the insured and becomes entitled to all rights and remedies which the latter has against any third party. This principle has been modified here to this extent that if the compensation or damage (less costs of litigation, if any) obtained by the Fund exceeds the cash benefit granted or advanced to the worker, the surplus will be made over to him ; but that the insured will not be liable to pay for any deficiency arising in the opposite case.

(v) As regards medical attendance, if the injury or accident occurs in or about the factory, the employer's doctor will no doubt apply first-aid to minimise the employer's future liability. But the worker will be entitled to medical treatment at the hands of the Fund's doctors or possibly hospital or specialist treatment, if this is available. The certificate of the Fund's doctor will no doubt be concerned with the actual fact of incapacity, but will incidentally state the doctor's own opinion as to whether the case is *likely* to be one for compensation or damages.

Whether or not the injured worker will be able to obtain compensation or damages under any special Act or under the common law is a matter of speculation. In the meantime, the responsibility for medical attendance in cases of injuries (whether ordinary or falling under the W. C. Act) and diseases of all kinds, devolves upon the Fund. It is, therefore, impossible to support the idea that such cases should be entirely ignored by the Fund.

The above provisions have been laid down in accordance with the practice elsewhere (particularly in Britain) and so as not to cause the slightest disturbance in the W. C. Act or Rules.

The working of the W. C. Act has been found to be defective (see *Industrial Labour in India*, I. L. O. Series A, No. 41, pp. 207-8 ; *Report of the Bihar Labour Enquiry Committee*, pp. 152-7 ; *Report of the Royal Commission on Labour in India*, pp. 296 and 307). One of the main causes of this has been the worker's ignorance of the law and the benefits to which he is entitled thereunder. Another is the lack of research in industrial diseases in India. If the Fund's responsibilities incidentally assist in the successful working of the Act, this should be advantageous to all concerned.

For various reasons, however, which are fully stated in Appendix XXVI, I am of the opinion that the present Workmen's Compensation Act should be scrapped and replaced by a scheme of insurance against Industrial Disability, covering both industrial accident and disease. This is necessary not only in the interests of workers (liable to accident and industrial disease), but also in the interests of the solvency of the present scheme which is closely inter-related with the subject-matter of the Workmen's Compensation Act, both in regard to medical treatment and payment of cash benefit. It is a superficial view which considers the two as separate and naively suggests that the Workmen's Compensation Act should be left where it is.

I.—A Time-Table of the Scheme.

An important matter requiring consideration is the appropriate time when the scheme would be put into operation. It is difficult at this stage fully to envisage the time-table of the scheme. But certain necessary stages might be indicated here.

(1) First stage :—Report on Health Insurance is released for consideration of Governments, Employers' Associations, Labour Unions, Medical Associations, etc., and their opinions and suggestions collected.

(2) Second stage :—Drafting of legislation.

(3) Third Stage :—Bill is considered, debated and passed into an Act.

(4) Fourth stage :—The nucleus of the Administrative Machinery at the Apex and in the Regions is established. Rules and regulations are framed under the Act.

(5) Fifth stage :—Regions, Centres and Sub-Centres with their offices are formed ; Central and Regional Boards and Local Committees are formed ; the nucleus of the Medical Machinery is established, and plans are laid out for the establishment of Health Centres, Dispensaries and Panel Centres ; cards, stamps and forms are prepared, printed and kept ready for distribution ; propaganda and information.

(6) Sixth stage :—Collection of contributions commence as from a notified date. Fund's Offices begin to function. Medical Units are gradually opened in important areas and panel doctors appointed in others.

(7) Seventh stage :—Six months after the commencement of collection of contributions or on a suitable date to be notified (which is not much later than that) cash and medical benefits begin to be administered.

These are the principal stages in the time-table. I do not wish to hazard any estimates as regards the time required for each stage.

As the fourth and fifth stages will necessarily have to precede the sixth stage of collection of contributions, it is clear that for six months or a year, the administrative organisation will have to be financed out of funds advanced by the Government of Inda. This advance may amount to Rs. 5 or 10 lakhs, and will be regarded as part of the guarantee account.

J.—Extension of the Scheme.

As the scheme is confined to certain major perennial factory industries in the beginning for purposes of experimentation, it is clear that its extension to other industries and occupations is a matter for future action as soon as sufficient experience of the scheme is available. Such extension, either by suitable stages, or, if possible, at one stretch, may be effected after a proper enquiry which may be instituted within five years from the commencement of the present scheme.

It is difficult to visualise at this stage all the problems arising from such an extension. I may, however, offer a few remarks on the possibilities of the extension of the scheme to different categories of workers.

As Commerce is closely related to Industry, the problem of extending the scheme so as to cover not only the commercial part of industrial undertakings, but also commercial undertakings proper, is bound to arise sooner or later. In the first place, non-inclusion of commercial, as of other types of, labour is likely to give rise to demarcation disputes. Secondly, the working conditions of commercial labour of the low-paid variety and its standard of life are practically on the same footing as those of industrial labour. Application of the scheme to commercial labour, moreover, is not likely to give rise to difficulties any more serious than in the case of industry. Under Commerce, apart from clerical and other staff, it will be necessary to cover small shop-keepers, and persons of limited income carrying on business on their own account. Generally, it would be safe to apply the criterion of liability to income-tax. If the person concerned does not pay income-tax, he will be regarded as eligible for insurance. Thus advantage can be taken of the existing income-tax machinery for deciding eligibility. Another class of workers which may have to be considered in connection with extension in the future consists of domestic servants, handicraftsmen sailors, etc. The special problems arising in each case will have to be carefully considered.

There would be immense difficulties in extending the scheme to agriculture. Agricultural labour in India is not only ill-organised but consists of a large mass of illiterate, ignorant and poverty-stricken people. The workers have no regular contracts of service and are not always engaged for definite periods of time. Even their employers are often illiterate and keep neither accounts nor registers. For all these reasons, it will be impossible to make the scheme work in relation to agricultural workers, until employment is regularised and legally controlled. Unfortunately, employment in India is still largely agricultural and if steps are not taken to extend health insurance or some form of medical assistance to agricultural labour, social security is bound to be lopsided and narrow in its scope. Much would depend upon the future prospects of industrialisation and of agricultural modernisation. There is a large mass of unwanted, landless agricultural labour here, apart from the class of small tenant-cultivators, causing economic congestion in rural areas, which will have to be drafted into industry, while agriculture itself must be mechanised and modernised. If this ideal is achieved, the problem of applying health insurance to these workers would be very much simplified.

K.—Indian States.

One last question remains and that is the position of the Indian States in regard to the present scheme. This has to be viewed from different angles. In the first place, there is the question of lack of uniformity in labour legislation as between British India and State India. Secondly, we have to consider how far the present scheme can be suitably applied to them, i.e., whether the general labour conditions there are in any way different from those in British India. Thirdly, if the States are willing to adopt British Indian standards in respect of health insurance and also the legal provisions relating to them, the next question will be whether they should not join an all-India scheme rather than have independent schemes of their own in each case. Finally, assuming that Indian States have independent schemes of their own, what provisions regarding reciprocity should apply to them as sēmi-sovereign political entities, standing on a footing somewhat different from the foreign governments of fully sovereign states? In the following paragraphs, I shall deal with these matters, but while doing so I must state that my contact with the States has been somewhat short in duration and I have not been able to visit all the major States personally. Moreover, statistical and factual material relating to labour conditions in the States, as is well-known, is extremely scanty. To remedy this, a special questionnaire (*vide* Appendix IV) was issued to the six major States (whose representatives attended Ministerial Labour Conferences).

As regards the first point, viz., lack of uniformity in labour legislation as between Provinces and States, reference may be made to the remarks of the Royal Commission on Labour (Report, pp. 472-4), who stated that "it would be a poor service to labour and the country so to raise standards in one part of India as to drive industry into another part where standards are lower," and that "so long as there exist side by side areas in which legislation is comparatively backward, there will be a handicap to progress in the rest of India." No doubt, labour legislation is but one of the many adverse factors affecting localisation in this way, taxation laws being perhaps even more important. And, moreover, it has even been contended that labour will tend to gravitate towards places where it receives fair treatment, although, I think, in view of the illiteracy and stay-at-home character of Indian labour, its mobility can hardly be said to be as great as that of capital. With the continuous growth of labour legislation in British India, however, the fear of British Indian industrialists that (*a*) their existing concerns might have to face severe competition from States, and (*b*) that industries might be "driven" from Provinces to States, becomes more and more justifiable. Fortunately, most of the leading Indian States, such as Baroda, Cochin, Gwalior, Hyderabad, Indore, Mysore and Travancore, have been forging ahead in the direction of progressive labour legislation, and have adopted, with suitable modifications, the principal labour laws of British India. This cannot, however, be said to be the case with the smaller States which are far more numerous and are scattered across the frontiers of Provinces throughout India. What is more important, most of these smaller States are politically so backward that it is unthinkable that the working-class population in them could organise themselves in such a way as to bring pressure upon their respective administrations with a view to better social conditions. When the Royal Commission on Labour reported, conditions were sufficiently desperate already, but, barring some of the major States mentioned above, it is difficult to believe that the comparative situation would not get worse, when modern schemes of social security are adopted in British India. I do not propose to dwell upon the measures which may be necessary to obtain conformity to general standards of labour legislation on the part of Indian States, as this is a well-worn topic. All that I wish to state is that not only progress of industries but also that of labour is likely to be seriously

jeopardised, if health insurance and allied measures are imposed upon Provinces only and are not simultaneously enacted in all the industrialised States.

This brings us to the second question as to how far the present scheme can be made applicable to factories operating in the States. There are four basic measures of labour legislation in British India with which, in the main, health insurance is intimately bound up, viz., the Factories Act, the Payment of Wages Act, the Workmen's Compensation Act and the Maternity Benefit Acts. The major States have, as already stated, generally adopted these with suitable modifications. There are Factories Acts in Baroda, Cochin, Hyderabad, Indore, Kashmir, Mysore and Travancore ; Workmen's Compensation Acts in Baroda, Cochin, Gwalior, Hyderabad, Indore, Mysore and Travancore ; Maternity Benefit Acts in Baroda, Cochin, Gwalior, Hyderabad, Indore and Mysore ; and Payment of Wages Acts in Baroda, Cochin, Gwalior, Indore and Travancore. It may thus appear that the basic legislative structure is, with one or two minor exceptions, available in all these major States, although it is not known with what degree of rigour the laws are being enforced. If, therefore, it is decided to introduce health insurance in these States, provided necessary steps are taken to amend and readjust existing measures to facilitate such introduction, there should not be any insuperable difficulty from this standpoint in doing so. The conditions of labour too are not materially different in the States from what they are in the Provinces, except perhaps that labour is less organised in the former. Detailed information regarding conditions of labour in some of the major States is given in Appendix XXVII, but here it might be convenient to summarise some of the main facts. Labour is migratory in almost all the States. *Badli* labour is prevalent in Hyderabad, Baroda and Indore, especially in the textile factories, but except in Indore and Baroda, not much progress has been made in the adoption of *badli* control systems. In Hyderabad and Indore, contract labour is not to be found, but in Baroda it is fairly widely prevalent, while in the Mysore gold mines about 30 per cent. of the labour force is on a contract basis, and in Travancore about 100 tea and rubber factories employ about 4,000 workers through contractors. The measures relating to *badli* and contract labour proposed in the present scheme can, I think, be applied without much difficulty in the case of these States. Trade union organisation does not seem to have made much progress in the States. In Mysore, only perhaps 35 to 40 per cent. of the labour force is organised, while in Indore the percentage is nearabout 25. In Travancore, there are 34 trade unions and include workers in cotton textiles and engineering. In Baroda, only cotton textile workers are organised to some extent, but in Hyderabad there is only one recognised trade union, viz., that of railwaymen. Thus, broadly speaking, the need for adopting a tripartite machinery for administering the health insurance fund will be felt in the case of States also. Likewise, the suggestion that the medical facilities provided by employers should be continued subject to the approval of recognised trade unions of workers will not work in the States any more than in the Provinces. Nor is the hope that dissatisfaction on the part of workers would be given vent to through trade unions, thus influencing the policy of employers' health insurance funds, likely to be realised. Finally, the period of wage payment is quite regular in Mysore, where it is generally a month, except in gold mining and coffee-curing, where it is a fortnight. In Hyderabad also it is a month : in Travancore, either a fortnight or a week : but in Baroda, which probably follows the Ahmedabad model in this as in other things, we find every conceivable period of payment, month, fortnight, week and *hafta* (the duration of which varies from 12 to 16 days). Information about other States was not available, but it seems that the considerations which have influenced me in deciding the month as the most suitable period for health insurance contributions also hold good in the case of States. On the whole, therefore, I do not see any reason why the present scheme should not be capable of application to factory labour in the States.

While, however, there is a clear case in favour of bringing pressure upon the States in order to secure uniformity of legislation in this regard, one cannot be equally sure about the next question, viz., participation by them in an all-India scheme. On the one hand, there will be an undoubted advantage, from the viewpoint of the States, in seeking financial safety by availing themselves of the principle of "pooling the risks," which is fundamental to all insurance. Secondly, a unified, national system of social insurance might be considered by some as one more bond bringing Provinces and States into closer contact with one another. Thirdly, uniformity of contributions and benefits and singleness of administration would be a great facility to labour and a factor helpful to its mobility, while at the same time, the financial liability of employers being uniform throughout India, there would be no interference with industrial localisation. Fourthly, unification would greatly assist measures of public health and prevention of epidemics, which necessarily imply a national policy and a national system of medical organisation. There are, however, some weighty reasons on the other side why participation by the States may not be feasible and even desirable. In the first place, although labour legislation might have been adopted on paper, one cannot be sure about the standards of administration and enforcement in every case, and hence in the possible absence of an efficient system of administration, which indeed is a basic factor, the whole scheme might be jeopardised. Secondly, until some sort of federal machinery comes into existence at the Centre, it may not be possible to secure that degree of conformity with ancillary laws and rules in the States which would be necessary for the successful operation of the scheme in them. Thirdly, not only the Governments of States but also employers and workers might prefer to have independent schemes, with the hope that this would ensure a greater degree of control by them over the affairs of the Funds. In fact, this seemed to be the desire of some of the official and other representatives interviewed by me. The conclusions at which we arrive are, therefore, as follows : One, that the States should be left to decide for themselves, whether in view of the advantages and drawbacks attaching to participation in an all-India scheme, they would join hands with the Provinces ; and two, that, if any States wish to do so, the health insurance authorities, on their part, must also consider the case of each from the viewpoint of administrative standards before agreeing to such a step.

If, however, all or some of the States choose to remain outside the all-India scheme, there arises the question of reciprocity. This is a question of technical importance only. On the assumption that there is a single, unified and centralised fund, for British as well as State India, obviously such a question need not arise ; but on the assumption of separate State funds, this matter becomes relevant. The absence of any provision for reciprocity, under such circumstances, might be unfair to British Indian labour working in the States concerned, and it might well happen that labour from British India is not put on par with indigenous State labour. Of course, if there is no health insurance in any particular State, there can be no question of reciprocity, as in that case there would be no disparity between British and Indian labour and State labour working in the State concerned. The extent of emigration from and immigration into the States can be judged from information supplied in Appendix XXVII. It appears that the extent is not very great in the case of Hyderabad and Indore ; but while in the case of Baroda and Mysore, emigration is slight, immigration is quite substantial. In view of this, the reciprocity provisions suggested in Chapter II, with suitable modifications, might be made applicable to such States as may elect to have their own schemes, and agreements might be entered into with them with a view to securing to British Indian labour the same facilities as are available to State labour.

REPORT OF THE ACTUARIAL ADVISORY COMMITTEE.

To

The Secretary to the Government of India,

Labour Department,

NEW DELHI.

SIR,

We have the honour to present our report on the points referred to us in the letter from your Department No. L-3019, dated the 13th December 1943.

The terms of reference of the Actuarial Committee were :—

" to consider and advise generally from the actuarial angle on the preliminary draft scheme prepared by Professor Adarkar and subsequent alterations thereof in the light of the views of the Government ..... and in particular on

(1) assessing within reasonable limits the financial implications of the scheme and

(2) the forms of cards and other statistics necessary to be collected in administering the scheme, linking up rules and setting up reserves ".

COLLECTION OF STATISTICS.

2. The collection of statistics and the forms, etc., to be devised for this purpose is a question different from and independent of the others included in our terms of reference. This is a matter which might be more appropriately discussed when we are in a position to know the final scheme as embodied in the Bill and after the regulations thereunder have been made. In this connection we may mention that Professor Adarkar has already obtained from the United Kingdom Government the forms they have in use in that country and they may well form a basis to work upon. Since we understood that the Government are anxious to have our report early we have reported upon the other points referred to us leaving this over to a later stage.

LINKING UP RULES.

3. We had at an earlier stage communicated our recommendations to Professor Adarkar regarding the changes necessary in the rules relating to linking up of two illnesses and his report as modified in this respect meets with our approval.

GENERAL FINANCIAL BASIS.

4. The system employed in the various countries vary but they can be broadly classified as coming under one of the two following.

(a) Actuarial (capitalization) basis and

(b) Assessment (budgetary) basis.

The actuarial basis is similar in principle to that employed by Life Assurance companies, where a level premium is payable throughout for a risk which increases with age, the excess contributions made when the insured is young being accumulated so as to be just sufficient to meet the deficiency at

the older ages. At its inception the scheme would embrace all existing employees most of whom would be above the age for which the contribution fixed would be adequate. It is therefore inevitable that under this system the fund would commence with an initial deficiency representing the aggregate of the initial excess of the capitalized value of the benefits payable over payments receivable, called actuarial reserve, in respect of these employees. The fund to begin with will have to be credited with this amount and subsequently also with the actuarial reserve for each individual admitted later to the scheme at an age older than the one for which the contributions have been calculated.

5. The assessment basis does not attempt to correlate the contributions to the age of the worker and merely preceeds on the principle that the contributions received in any predetermined short period should be sufficient to pay for the benefits granted in that period. The contributions can, if found necessary, be altered at the end of each such period. Usually a " protective fund " is also set up to guard against adverse fluctuations in the sickness experience. This system has been adopted in almost all countries of the world, the United Kingdom being perhaps the only important exception.

6. After a careful consideration of the scheme in all its aspects we have come to the conclusion that the assessment system should be adopted at the inception of the scheme. It may not be necessary to detail all the reasons which have prompted us to recommend this system but one may be mentioned. According to the report of Professor Adarkar it is proposed to make a beginning on a modest scale only. In course of time the benefits will be augmented and the contributions will have to be increased as a consequence. The assessment system in view of its flexibility will more readily lend itself to changes of this nature than the other system. Till, therefore, the benefits and contributions become reasonably stabilized, the assessment system could be used with advantage.

7. We would like to point out that under this system it may sometimes happen that in a particular year the outgo exceeds the income, resulting in a small deficit. The Government guarantee,—we recommend that this should remain as a permanent feature of the scheme,—however, will enable the Fund to tide over this temporary difficulty and the Fund should soon be able to repay the advances out of the income of the future years. We do not anticipate that in practice any Provincial Government will be called upon to advance a large amount in terms of this guarantee. We would like to emphasise that these " deficits " should not be confused with what is termed an actuarial deficit and no attempt should be made to deal with any positive or negative balances of the Fund except in pursuance of an actuarial investigation and under actuarial advice.

Sickness Statistics Available.

8. When Great Britain started its National Health Insurance Scheme, the Friendly societies in that country had been in existence for well over half a century and the rates of sickness experienced by the persons assured with these societies formed a reliable basis on which the scheme could be based. The position in India in this respect is however different. Professor Adarkar has at considerable pains collected statistics relating to the sickness experience of the workers of some companies. But the chief drawback of the statistics is that the companies had not been keeping their books in such a way as to enable rates of sickness to be calculated on a uniform definition of the term " sickness ". Some have therefore returned all periods of sickness, whether or not

sick benefits were paid; while others have returned only periods of sickness for which benefits were paid. We had therefore to exclude the statistics furnished by some companies thus reducing the volume of data available but the remainder, though rather scanty, enabled us to come to the conclusion that the rate of 14.6 days of sickness per year which is the maximum the statistics reveal, can be taken as a basis to work upon in the beginning.

Financial Implications of the Scheme.

9. In his report, Professor Adarkar has allocated 42.5 per cent. of the total receipts for providing the medical benefits and has made a provision of 12.5 per cent. for the entire administrative expenses inclusive of expenses incurred in the administration of the cash benefits, thus leaving a balance of 45 per cent. for the cash benefits and to create a reserve fund if any that may be set up.

10. We recommend that 5 per cent. should be set apart to constitute a Contingency Reserve Fund. Such a fund is necessary under the proposed assessment system to meet sudden unexpected increase in the claim or a falling off in contributions. Miscellaneous sources of income not taken into account in the calculations of the rates of contribution, may also be credited to this Fund.

11. In addition to the Contingencies Reserve Fund mentioned above, it is necessary in a country like India, which is afflicted with frequent epidemics over wide areas that a separate Epidemic Reserve should be created. We agree with Professor Adarkar that this should be considered a responsibility of the State and we have not therefore recommended that any portion of the contributions should be utilised towards the creation of this Fund.

12. The balance of 40 per cent. which is available to meet the cash benefits will support in the case of a class A worker a rate of sickness *ranking for benefit* of 12.4 days per year, the corresponding rates for B and C class workers being 16.1 and 26.7 days respectively. It is not proposed to keep separate funds for these classes and it is only necessary to consider whether the contributions for all the three classes taken together will be sufficient to meet claims, keeping in mind the likely distribution among the three classes. So far as we are able to judge from the statistics at our disposal and by a comparison with the sickness rates in other countries we consider that the scale of contributions proposed provides a reasonable basis on which a beginning can be made till it is possible to say something more definite under this head on the basis of an analysis of the statistics provided by the Fund itself.

13. We are, however, not in a position to make any forecasts as to the exact future financial implications of the scheme (if that expression is interpreted to mean anything more than testing the adequacy of the contributions on the basis of the statistics furnished to us). We are at present groping in the dark as to the essential elements entering into the calculations. Sickness rates vary not only with age but also with occupation and industry and it is well known that the sickness rates are also affected by geographical distribution of the workers. The statistics furnished by Professor Adarkar in this connection are not of sufficient volume to enable us to appraise the effect of the various factors on the sickness rates. It must also be remembered that the introduction of a scheme like this has a tendency to push up the sickness rates or, to be more exact, the claims rate.

14. Every country has had to face this difficulty relating to lack of statistical material and it cannot be too strongly emphasised that this initial difficulty cannot be advanced as an argument for not embarking on the scheme.

The scheme detailed by Professor Adarkar is by no means an ambitious one and contains some important provisions for limiting the strain on the fund from chronic claimants which the experience in the United Kingdom shows is an important source of loss. The usual provisions relating to " qualification period " also provide a valuable safeguard and due to their operation the claims during the first two years of the scheme will be low and the consequent saving in outgo will enable the contingencies Reserve Fund being augmented. By the time the first actuarial investigation falls to be made, some valuable data will have accumulated thereby enabling the actuaries to calculate the contributions with greater precision and also to make more accurate forecasts as regards the financial implications. Meanwhile we have no hesitation in recommending that a start may be made with the scheme drawn up by Professor Adarkar.

General.

15. We would like to stress one point which we are sure Professor Adarkar himself is aware of, that a high standard of efficiency in the administration of a scheme like this is a *sine qua non* for its success. Unless malingering is effectively controlled the very basis of the scheme may be upset. In the United Kingdom the problem does not arise in an acute form as the various approved societies are more or less financially independent, with the result that every member of the society is interested in the soundness of the Fund with which he is insured and acts more or less as an unofficial sick visitor. Under the proposed scheme, however, there will be a central fund backed by Government guarantee and on this account it is quite conceivable that the officer in charge of the local units and the insured worker would naturally feel that the money comes out of a bottomless purse. Although Professor Adarkar himself has provided for certain safeguards to reduce malingering we hope that this point will not be lost sight of in the practical administration of the scheme.

16. The scheme should provide for continuous collection and analysis of data relating to its various elements for periodical actuarial investigation and recommendations as regards surpluses and deficits and for technical supervision. Such a continuous analysis will be useful in particular for detecting and checking malingering on any extensive scale. With this end in view, it is strongly recommended that an actuary should be associated with the management of the scheme.

17. Though not strictly within our terms of reference we would like to record our recommendations on a certain aspect of the administration of the medical benefit. We feel that if the medical benefits are administered by the provinces it will not be possible to ensure that such benefits will be administered on a uniform basis all over the country. Moreover, the surplus in any one province will not be available for meeting the deficit in any other province. We would therefore recommend that the medical benefits also should be administered centrally. If however due to any insuperable difficulty the administration has to be delegated to the provinces it should be stipulated that the insured worker should get as of right certain well-defined benefits commensurate with the amount allotted for the purpose from the contributions received and these benefits must be additional to what the worker would normally get as a member of the public. Any excess of the actual cost in this regard over the amounts allotted out of the central fund to the provinces on actuarial recommendation should be met by the province concerned.

18. Before closing we have to record herein the high value of the Preliminary Report which Professor Adarkar has prepared embodying the scheme.

His presence at the meeting of the Actuarial Committee was very helpful, as this enabled us to have those aspects of the scheme explained to us which could not naturally be elaborated in a Preliminary Report.

19. Our thanks are also due to Mr. A Rajagopalan, F.I.A., Assistant Superintendent of Insurance, who rendered great help to us as the Secretary of the Actuarial Committee. He and Mr. P. V. Krishnamurthy, F.I.A. attended the Committee meetings and helped us substantially in our deliberations.

We have the honour to be,

Sir,

Your most obedient servants,

L. S. VAIDYANATHAN, M.A., F.I.A.,
Chairman.

B. K. SHAH, B.COM., F.I.A.,
S. N. VAIDYA, B.COM., F.I.A., } *Members.*

A. RAJAGOPALAN, F.I.A.,
Secretary.

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APPENDIX 1.—Letters addressed by the Government of India to Provincial Governments, States and Associations of Employers and Workers.

LETTER NO. L3019, DATED THE 8TH MARCH 1943, FROM THE UNDER SECRETARY TO THE GOVERNMENT OF INDIA, DEPARTMENT OF LABOUR, TO ALL PROVINCIAL GOVERNMENTS AND CHIEF COMMISSIONERS.

I am to refer to this Department's letter No. L3019, dated the 19th March, 1942. Replies to that letter indicate a general consensus of opinion to the following effect :—

(1) Provincial Governments are prepared to give a guarantee to a fund which should preferably be a Central fund.

(2) The suggested programme in paragraph 5 of the letter, dated 15th March, 1942 is suitable.

(3) The industries to which it is proposed to extend the scheme are suitable. (Some suggestions as to details have been made in this respect).

2. The Government of India have therefore decided to proceed on the preparation of a rough scheme of sickness insurance. It was proposed originally that this should be done by a small committee of about three experts. On further consideration the Government of India deemed it advantageous to entrust the work to an officer on special duty. This officer will, of course, be assisted by the office of the Superintendent of Insurance to the Government of India. The officer will also consult Provincial Governments and take advice from a panel of advisers representing employers and workers. A copy of the letter being addressed to the All-India associations of employers and workers is attached for information.

3. Professor B. P. Adarkar of the Allahabad University has been appointed to the post of special officer, which has been created for a period of three months in the first instance. He is taking up his duties on the 16th March 1943 and his headquarters will be at Bombay.

4. Professor Adarkar is being authorised to address Provincial Governments/you in all matters germane to his enquiry. I am to request that he may also be authorised to address direct, in suitable cases, the Labour Commissioners and Chief Inspectors of Factories in your area, to avoid delay.

5. The Government of India have no doubt that your Government/you will extend the fullest co-operation to Professor Adarkar in his enquiry.

LETTER NO. L3019, DATED THE 8TH MARCH, 1943, FROM THE UNDER SECRETARY TO THE GOVERNMENT OF INDIA, DEPARTMENT OF LABOUR, TO EMPLOYERS' FEDERATION OF INDIA, ALL-INDIA ORGANISATION OF INDUSTRIAL EMPLOYERS, ALL-INDIA TRADE UNION CONGRESS, INDIAN FEDERATION OF LABOUR.

I am to refer to the discussion on the subject of sickness insurance by the Hon'ble the Labour Member with your representatives at Calcutta in January 1942 and the subsequent discussion at the Third Labour Conference held in the same month.

2. The Government of India addressed Provincial Governments and in the light of their response have now decided on the following course of action :—

(1) Provincial Governments have agreed to give a guarantee to reimburse a Central sickness insurance fund. This will be necessary to ensure the operation of the fund and disbursement of benefits as there may arise uncertainties in the working of the scheme.

Since the guarantee has been forthcoming it is possible to proceed in formulating a rough scheme.

(2) The Government of India have appointed Professor Adarkar of the Allahabad University as officer on special duty, with headquarters at Bombay, for a period of three months in the first instance He will have the expert assistance of the office of the Superintendent of Insurance and will consult Provincial Governments and also take advice from a panel of advisers representing employers and workers.

(3) After a rough scheme has been prepared Provincial Governments and associations of employers and workers would be asked to express their views before any scheme is finally decided upon legislation introduced for the purpose.

(4) The scheme will be prepared for cotton and jute textile industries and heavy engineering industries in the first instance.

3. I am to express the hope that your Federation/etc. will agree with the course of action and will assist Professor Adarkar in the preparation of a rough scheme.

4. I am to request that your Federation/etc. may nominate an adviser (or two advisers if you so desire) whom Professor Adarkar may consult in his enquiry. He is being authorised to communicate direct with employers' and workers' associations on questions relating to his enquiry.

5. Until the special officer's exact address is known, communications intended for him may kindly be addressed c/o the Labour Office, Secretariat, Bombay, and the names of the advisers nominated by you may be sent direct to the special officer, with copies to this Department.

EXPRESS LETTER NO. D-1803-I-B/43, DATED THE 6TH APRIL 1943 FROM THE POLITICAL DEPARTMENT, TO THE RESIDENTS—HYDERABAD, MYSORE, CENTRAL INDIA, GWALIOR, BARODA, MADRAS STATES.

From the enclosed copy of correspondence it will be seen that the Government of India have appointed Prof. B.P. Adarkar of the Allahabad University as an officer on special duty to prepare, i

consultation with Provincial Governments and employers' and workers' associations, a rough scheme of sickness insurance in respect of cotton and jute textile industries and heavy engineering industries in the first instance. The Government of India have suggested and the Crown Representative agrees that Mr. Adarkar's enquiry should also take account of circumstances obtaining in the States of Hyderabad, Mysore, Indore, Gwalior, Baroda and Travancore, which were represented at the Plenary Conference. It is, therefore, requested that, if you see no objection, you will invite H. E. H. the Nizam's Govenment

Mysore Government
Indore Government
Gwalior Darbar
Baroda Government
Travancore Government

to assist Mr. Adarkar in his enquiry by supplying such information as he may require relating to industries in the State. As he has to complete his enquiry before the 15th July 1943, the State may be asked kindly to get into direct touch with him at the Council Hall, Bombay, 1.

LETTER No. L3019, DATED THE 30TH APRIL 1943, FROM THE UNDER SECRETARY TO THE GOVERNMENT OF INDIA, DEPARTMENT OF LABOUR, TO ALL PROVINCIAL GOVERNMENTS AND CHIEF COMMISSIONERS.

I am to refer to the correspondence ending with this Department's letter No. L3019, dated the 8th March 1943.

2. It was suggested in para. 6 of this Department's letter No. L3019 of the 19th March 1942 that in the first instance the sickness insurance scheme should be applied to cotton and jute textile industries and heavy engineering industry. This was found generally acceptable. One Government however indicated that the term engineering industry covers a very large number of factories, including railway workshops, constructional engineering plants, naval and mercantile dockyards, foundries, smelting and refining plants and munitions factories, small workshop, etc. The application of the term heavy to single units in this group would be very difficult to determine unless its exact connotation is clearly defined

3. As regards textiles, another Government suggested that this should specifically include rayon.

4. Professor Adarkar has now made the following suggestions as regards the industries to which the scheme may apply :—

(*i*) It will be impossible to define cotton textiles, jute textiles and heavy engineering industry in such a way as to avoid legal loopholes. The reason why these industries were mentioned at the discussion at the Labour Conference was that these are well organised industries. The question of organisation does not however arise to the same extent as that of legal enforcibility. Most of the labour laws are applied without difficulty to factories covered by the Factories Act and it would be very suitable to have a sickness insurance scheme applied to all industries covered by the Factories Act.

(*ii*) If, however, it is considered necessary to select only a few industries in the first instance, the best course would be to select (*a*) oil textiles, (*b*) all engineering and all minerals and metal factories covered by the Factories Act.

5. The definition under the second suggestion will exclude industries connected with food, drink, cement, paper, matches, mines and plantations and some others. The terms then would, for practical purposes, be fairly clear.

6. I am to request that the views of the Provincial Government/your views may be communicated *as soon as possible* so as to facilitate Professor Adarkar's work in preparing a concrete draft scheme.

LETTER No. L3019, DATED THE 31ST JULY 1943, FROM THE DEPUTY SECRETARY TO THE GOVERNMENT OF INDIA, DEPARTMENT OF LABOUR, TO ALL PROVINCIAL GOVERNMENTS AND CHIEF COMMISSIONERS.

I am to refer to this Department's letter No. L3019, dated the 30th April 1943.

2. Among the Provincial Governments and Administration who have replied, only the Governments of Sind, Assam and Baluchistan are prepared to go as far as alternative (*i*) in para. 4 of the letter referred to is concerned. All other Governments and Administrations who have replied prefer alternative (*ii*) in para. 4 of the letter. Two of these Governments would restrict the application of the scheme only to large undertakings defining this by reference to the number of workmen employed.

3. The general consensus of opinion being therefore in favour of alternative (*ii*), the Government of India are instructing the Special Officer that his draft scheme should cover industries mentioned in alternative (*ii*) in para. 4 of the letter, namely :—

(*a*) all textile industries,

(*b*) all engineering and all minerals and metal factories, covered by the Factories Act.

LETTER No. L3019, DATED THE 15TH DECEMBER 1943, FROM DEPUTY SECRETARY TO THE GOVERNMENT OF INDIA, DEPARTMENT OF LABOUR, TO ALL PROVINCIAL GOVERNMENTS AND CHIEF COMMISSIONERS, A.

I am to refer to the correspondence ending with this Department's letter No. L3019, dated the 31st July, 1943.

It was decided on the basis of the general consensus of opinion that the Special Officer should draft the scheme so as to cover —

(*a*) all textile industries,

(*b*) all engineering, and all

(*c*) minerals and metal factories,

covered by the Factories Act, 1934.

It has been suggested to the Special Officer by several parties concerned that the scope of the Scheme as defined above is rather narrow in its application and that the operation of the Scheme under the present arrangement will not be free from certain practical difficulties. It would be difficult at times to decide under which of the three groups of the industries a particular factory fell. In cases where a concern is carrying on overlapping business the classification is bound to be quite arbitrary. This will not, however, create any difficulty so long as the factory is covered by the three specified groups of industries as there is no differential treatment in-between the groups. But it is evident that disputes regarding demarkation between groups which are included and those which are not will be quite frequent under the present Scheme and a decision on this point may cause discontentment in certain cases. The three classes of industries among them already cover about 76% of labour employed in non-seasonal factories and the extension of the Scheme to the remaining classes of industries is not expected to present any difficulty.

In the circumstances the Government of India would be grateful if the Provincial Government/you will kindly consider the question of extension of the scope of the Scheme at least to all perennial factories covered by the Factories Act and thereby including other groups of industries also, *viz.*, "Food, Drink and Tobacco", "Chemicals, Dyes, etc.," "Paper and Printing", "Wood, Stone and Glass", "Gins and Presses", "Skins and Hides" and "Miscellaneous".

It is requested that the views of the Provincial Government/Administration may kindly be furnished to this Department *as early as possible* to enable the Special Officer to proceed further with the Scheme.

LETTER NO. L3019, DATED THE 16TH JUNE 1944, FROM UNDER SECRETARY TO THE GOVERNMENT OF INDIA, DEPARTMENT OF LABOUR TO ALL PROVINCIAL GOVERNMENTS AND CHIEF COMMISSIONERS.

Reference this Department's letter No. L3019, dated the 15th December 1943.

It has been decided that for the present sickness Insurance Scheme will be confined to the previous list *viz.*,

(*a*) all textile industries,

(*b*) all engineering,

(*c*) all minerals and metal factories covered by the Factories Act, 1934

APPENDIX II.—NAMES AND ADDRESSES OF ADVISERS ON THE PANEL.

1. S. C. Joshi, Esq., M.A., LL.B., Advocate, Soman Building, 'Girgaum Road, Bombay 4.	All India Trade Union Congress.
2. S. S. Mirajkar, Esq., c/o The Bombay Girni Kamgar Union, Lal Bawta, Parel, Bombay.	
3. V. M. Tarkunde, Esq., Bar-at-Law, Ratilal Mansions, Parekh Street, Bombay.	Indian Federation of Labour.
4. George Lobo, Esq., c/o Bombay Committee of the Indian Federation of Labour, Ratilal Mansions, Parekh Street, Bombay 4.	
5. J. C. Lancashire, Esq., c/o Messrs. Forbes, Forbes Campbell, & Co., Bombay.	
6. G. M. Garrie, Esq., Vice-Chairman, Indian Jute Mills Association, The Royal Exchange, Clive Street, Calcutta.	Employers' Federation of India.
7. A. H. Bishop, Esq., Deputy Chairman, Indian Engineering Association and Managing Director, Messrs. Guest Keen, Williams & Co. Ltd., c/o Royal Exchange Clive Street, Calcutta.	
8. Sir Shri Ram, 22, Curzon Road, New Delhi.	All India Organisation of Industrial Employers.
9. Kasturbhai Lalbhai, Esq., Pankore Naka, Ahmedabad.	

APPENDIX III.—NAMES OF OFFICIALS AND REPRESENTATIVES OF EMPLOYERS' AND WORKERS' ASSOCIATIONS, OF THE MEDICAL PROFESSION, ETC., INTERVIEWED.

Station.	Date.	Names.
Bombay ..	29th March 1943 ..	Mr. S. V. Joshi, Officiating Labour Commissioner, Bombay; Mr. V. P. Keni, Assistant Labour Commissioner, Bombay.
	1st April 1943 ..	Mr. S. S. Mirajkar, (Adviser) All-India Trade Union Congress.
	2nd April 1943 ..	Mr. J. C. Lancashire, (Adviser) Employers' Federation of India.
	3rd April 1943 ..	Mr. V. M. Tarkunde, (Adviser) Indian Federation of Labour.
	5th April 1943 ..	Mr. N. M. Joshi, General Secretary, All-India Trade Union Congress; Mr. S. C. Joshi, (Adviser) All-India Trade Union Congress; Miss Shanta Bhalerao, Assistant Secretary, All-India Trade Union Congress.
	11th May 1943 ..	Mr. L. S. Vaidyanathan, Actuary, Oriental Life Insurance Co., Bombay; Mr. F. J. Currion, General Secretary, National Union of Railwaymen of India, Burma and Ceylon.
	12th May 1943 ..	Mr. Kasturbhai Lalbhai, (Adviser) All-India Organisation of Industrial Employers; Mr. A. H. Bishop, (Adviser) Employers' Federation of India; Mr. A. Hughes, Commissioner of Labour, Bengal.
	13th May 1943 ..	Mr. George Lobo, (Adviser) Indian Federation of Labour.
	14th May 1943 ..	Mr. S. R. Deshpande, Director, Cost of Living Index Scheme.
	12th July 1943 ..	Mr. C. D. Sharp, Actuary, Gresham Life Assurance Co., Bombay.
	14th July 1943 ..	Mr. V. M. Tarkunde, (Adviser) Indian Federation of Labour.
	4th September 1943	Mr. Vaikunth Lallubhai Mehta; Dr. F. N. A. Moss. Dr. M. B. Velkar, Dr. J. E. Spencer, Dr. N. J. Modi, Dr. R. J. Vakil, Dr. K. S. Bharucha—President and Members of the Bombay Medical Union.
	11th September 1943	Mr. G. S. Diwan, Actuary.
	14th September 1943	Dr. H. P. Dastur.
	15th September 1943	Dr. K. R. Mehta.
	18th September 1943	Mr. N. M. Joshi, General Secretary, All-India Trade Union Congress; Miss Shanta Bhalerao, Assistant Secretary, All-India Trade Union Congress.
	14th October 1943..	Mr. J. C. Lancashire, (Adviser) Employers' Federation of India.
Ahmedabad ..	7th April 1943 ..	Mr. S. P. Dave, Mr. N. H. Shaikh, Mr. A. S. Pandya, } Textile Labour Association. Mr. C. B. Kumar, Ahmedabad Millowners' Association.
	16th July 1943 ..	Seth Sakar Lal Balabhai, Mr. Umarwadia, Seth Ratilal Nathalal, Seth Ramanlal Lallubhai, Mr. Gautam Sarabhai, Seth Kasturbhai Lalbhai, Seth Amritlal Harigovind Das Seth Himatlal Kalidas—On behalf of the Ahmedabad Millowners' Association; Mr. B. T. Datar, Assistant Labour Commissioner, Ahmedabad.
	17th July 1943 ..	Mr. S. P. Dave, Mr. A. S. Pandya, Mr. M. M. Mehbi—Textile Labour Association.
New Delhi ..	16th March 1943 ..	Mr. D. T. Jack, Labour Adviser to the Government of India; Mr. R. S. Nimbkar, Lahour Welfare Adviser.
	12th April 1943 ..	Mr. D. P. Gupta, Delhi Cloth Mills; Mr. Agarwal, Birla Mills Delhi; Mr. G. C. Mukerjee, Office of the Superintendent of Industries, Delhi; Sirdar Saheb Mehtab Singh, Superintendent of Industries, Delhi; Mr. Dalip Singh Chowdhury, Mr. Sant Chavan, Mr. Piyara Lall—Employees' Representatives.
	13th April 1943 ..	Mr. A. S. Banavalikar, Labour Officer, Delhi Cloth Mills.
	16th April 1943 ..	Mr. B. Shiva Rao.
	17th April 1943 ..	Mr. D. T. Jack, Labour Adviser to the Government of India.
	18th April 1934 ..	Dr. P. P. Pillai, Director, International Labour Office (Indian Branch).
	3rd July 1943 ..	Sir Shri Ram, (Adviser) All-India Organisation of Industrial Employers.
	19th July 1943 ..	The Director General, Indian Medical Service.

New Delhi—*contd.*	29th October 1943	Mr. S.H.Y. Oulsnam, Joint Secretary, E. H. & L. Department; The Director General, Indian Medical Service; The Surgeon-General, Bombay; The Surgeon-General, Bengal; The Surgeon-General, United Provinces.
Simla ..	15th April 1943 ..	Mr. P. V. Krishnamurti, Officiating Superintendent of Insurance; Mr. A. Rajagopalan, Assistant Superintendent of Insurance; Mr. C. S. A. Padmanabhan, Officiating Assistant Superintendent of Insurance.
Calcutta ..	21st April 1943 ..	Mr. K. C. Roy Choudhry, President, Indian Federation of Labour, Bengal; Mr. S. N. Mondal, Indian Federation of Labour, Bengal; Dr. Mallick; Mr. Bankim Mukerjee, Trade Union Congress; Mr. Sisir Roy; Mr. Indra Babu, Press Employees' Association.
	22nd April 1943 ..	Mr. Nandlal Bose; Mr. S. Upadhaya, Calcutta Corporation Workers' Union; Mr. Tazuddin Ahmed, Secretary, Bengal Chamber of Labour; Mr. Afid Hussain, Secretary, Railway Factory Workers' Union; Mr. S. K. Prammanik, General Secretary, Bengal Provincial Trade Union Congress; Mr. Sisir Roy; Mr. S. N. Mondal; Mr. K. K. Sinha Mr. A. Hughes, Labour Commissioner, Bengal; Mr. S. K. Prammanik; Mr. Mrinal Kanti Bose, Trade Union Congress; Mr. G. M. Garrie, (Adviser) Employers' Federation of India; Mr. A. H. Bishop, (Adviser) Employers' Federation of India. Mr. J. J. B. Sutherland, Mr. W. D. Bryden, Mr. H. C. Brown and other representatives of the joint Committee of the Indian Jute Mills and the Indian Engineering Associations. Mr. A. Hughes, Labour Commissioner, Bengal.
	25th October 1943	Mr. A. Hughes, Labour Commissioner, Bengal; Mr. G. M. Garrie, (Adviser) Employers' Federation of India; Mr. A. H. Bishop, (Adviser) Employers' Federation of India; Mr. J. J. B. Sutherland, Deputy Secretary, Bengal Chamber of Commerce; Mr. W. D. Bryden, Assistant Secretary, Bengal Chamber of Commerce.
	26th October 1943	Mr. P. R. Gupta; Capt P. B. Mukerji, Dr. R. Sinha, Dr. Mumtaz Ahmed, Dr. P. K. Guha, Dr. B. P. Neogy, Representatives of the Indian Medical Association
Jamshedpur ..	24th April 1943 ..	Mr. M. Homi, President of the Labour Federation, Jamshedpur; and vice President, Indian Federation of Labour, Mr. P. Bhattacharji, President, Labour Union, Jamshedpur; Mr. Bimal Sen, Assistant Secretary, Bihar Provincial Indian Federation of Labour; Mr. K. B. Singh, Assistant Secretary, Mosoboni Mines Labour Union; Mr. N. C. Paul, General Secretary, Cable Workers' Union; Mr. Marina Khan, Treasurer, Cable Workers' Union; Mr. Mahomed Hussain; Mr. V. B. Sukla, Assistant Labour Commissioner, Bihar; Col. Henderson, General Manager, Tinplate Company of India, Golmuri; Mr. Pai, Secretary, Wire Products Ltd., Tatanagar; Mr. Varma, Assistant Chief Controller of Accounts, Tata Iron and Steel Co., Jamshedpur; Mr. Raja, Budget Assistant, Tata Iron and Steel Co., Jamshedpur; Mr. D. Narasingh, Asistant Labour Welfare Officer.
Nagpur ..	26th April 1943 ..	Mr. P. J. Gimi, Spinning Master, Empress Mills, Nagpur; Mr. Jijibhoy K. Divecha, Manager, Model Mills Nagpur; Mr. S. H. Batliwala, Deputy Agent, Tata and Sons; Rao Bahadur Chandorkar, Labour Commissioner, Nagpur; Mr. Gour, Labour Officer; Mr. G. M. Mote; Mr. D. S. Paranjpe; Mr. T. Mahajan, President, Nagpur Textile Union; Mr. V. G. Balwaik, Acting President C. P. & Berar Textile Workers' Federation; Mr. C. Hansade, General Secretary, Nagpur Textile Union; Miss Shanta Bhalerao, Assistant Secretary, All-India Trade Union Congress.

Cawnpore ..	29th April 1943 ..	Mr. Harishankar Bagle, U. P. Chamber of Commerce ; Mr. Tinker, Employers' Association of Northern India ; Mr. H. A. Wilkinson, Employers Association of Northern India ; Mr. J. V. Krishnan, Secretary, Merchants' Chamber of U. P. ; Mr. D. M. Arundale, Secretary, Employers Association of Northern India ; Sir Padampat Singhania ; Mr. M. C. Pant, Labour Officer ; Mr. Rashid, Assistant Labour Welfare Officer ; Mr. J. E. Pedley, Labour Commissioner ; Mr. A. Hai, Chief Inspector of Factories, United Provinces ; Mr. S. C. Mitra, Secretary, Provincial Indian Federation of Labour ; Mr. G. V. Karlekar, Branch Secretary, Indian Federation of Labour ; Mr. M. C. Pant, Labour Officer.
Madras ..	19th May 1943 ..	Mr. M. J. Bhuta, Mr. P. M. Balasubramania Mudaliar, Mr. Bhavanidas D. Khanderia, Mr. C. Ranganayarulu Chetty, Mr. P. Raghavan Nair, Mr. V. Pandurangaiya, Mr. Usuff Sait, Southern India Chamber of Commerce. Mr. A. R. L. Pathy, Labour Officer ; Mr. C. G. Reddy, Factory Inspector Mr. H. S. Town, Mr. P. Reid, Mr. N. W. Lowndes, Mr. J. M. Smith, Mr. S. T. Wicks, Mr. C. P. Johnstone, Mr. G. G. Armstrong, Chairman, Madras Port Trust, Mr. H. Rangarao, Mr. A. S. Killick, Mr. F. G. Hadden, Mr. B. O. Ellis, Mr. S. J. Archer, Employers' Federation of Southern India. Mr. F. R. Brislee, Labour Commissioner ; Mr. K. Jayaram, Secretary, Madras, Pencil Factory Workers' Union ; Mr. K. K. Sharma, Vice-President, Trade Union Congress ; Mr. P. S. V. Nanavaty, General Secretary, Press Workers' Union, Madras ; Mr. S. Guruswamy, President, M. S. M. Railway Employees' Union.
	20th May 1943 ..	Mr. F. R. Brislee, Labour Commissioner.
Coimbatore ..	22nd May 1943 ..	Mr. N. V. Singavanam, Conciliation Officer, Coimbatore' Diwan Bahadur C. S. Ratnasabhapathi Mudaliar ; Mr. R. K. Kandaswami Chettiar ; Mr. G. Ramaswamy Nadar ; Mr. Norman May ; Mr. Thanga Velu, Mr. J. Simon Paul Mr. K. V. Purushothaman, Coimbatore Mill Workers, Union.
Madura ..	24th May 1943 ..	Mr. S. R. Varadarajulu Naidu, President, Madura Labour Union.
	25th May 1943 ..	Mr. C. S. Rangachari, Meenakshi Mills, Madura ; Mr. N. S. Sundarachari, Mahalaxmi Mills, Madura. Mr. Fernandez Inspector of Factories, Madura ; Mr. A. Marshall, Madura Mills, Madura.
Bangalore ..	28th August 1943 ..	Mr. T. Rajamani, Assistant Commissioner of Labour, Mysore ; Mr. A. N. Chelimah, Secretary, Sri Krishna Mills, Mysore Mr. Kale, Labour Officer, Minerva Mills ; Mr. A. Nisbett, Managing Director, Woollen, Cotton and Silk Mills, Mysore ; Mr. R. N. Misra, General Manager, Mysore State Railway ; Mr. N. Rama Rao, Retired Director of Industries and Commerce, Mysore ; Dr. V. V. Monteiro, Senior Surgeon in Mysore ; Mr. M. A. Gopalaswami Iyengar, President, Sri Rama Weaving Shed Labour Association, Bangalore City; Mr. Ramachandra, President, Kolar Goldfield Labour Association ; Mr. P. M. Selvamani ; Mr. B. G. A. Mudaliar, Labour Commissioner in Mysore ; Mr. T. Rajamani, Assistant Commissioner of Labour, Mysore.
Baroda ..	30th September 1943	Mr. Chiman Lal, Mr. Krishnandas, Representatives of Labour Association in Baroda. Mr. Balwantrai Desai, Labour Officer ; Mr. Chaturbhuj Das Chimanlal, President, Federation of Baroda State Mills and Industries ; Mr. Ratilal Patel, Secretary, Jagdish Mills, Baroda ; Mr. Ramalal Chimanlal, Sri Yamuna Mills, Baroda ; Mr. Krishnadas Chimanlal, Baroda Spinning and Weaving Company, Baroda ; Mr. Banwantrai Manganlal Trivedi, Secretary, Federation of Baroda State Mills and Industries. Mr. P. K. Bhatt, Secretary, Shri Sayaji Mills, Baroda.

APPENDIX IV—The Questionnaires Issued.

I.—*Sickness Insurance (General).*

[*N.B.*—Replies to this questionnaire including memoranda if any, may be addressed to B.P. Adark Esquire, M.A. (Cantab.), Officer on Special Duty, Sickness Insurance, Government of India, Departmen of Labour, Council Hall, Bombay. (1), so as to reach him not later than the 15th of May, 1943.]

1. *Worker's Eligibility to Contribute.*—Under what circumstances should the worker be made to contribute or have the right to contribute ? In this connection, consider the following types of workers and other points :—(i) perennial workers, (ii) principally industrial but subsidiarily agricultural, (iii) seasonally industrial, (iv) *Badli* or substitute worker, (v) temporarily unemployed, (vi) sick, (vii) invalid, (viii) absent on leave, with or without pay, (ix) resigned or dismissed, (x) transferred, (xi) manual or non-manual, (xii) apprentices, (xiii) during strikes and lock-outs, (xiv) income limit, upper and lower, if any, (xv) age limits, upper and lower, if any.

2. *Eligibility to receive Benefits.*—Who will be eligible to receive benefits ? In the event of the insured's death, should the survivors be entitled to receive any refund or gratuity ? If any worker with draws from the Fund for any reason, should he be entitled to any refund ?

3. *Contributions.*—What should be the contributions of (a) Employers, and (b) Workers, respectively? Should the rates be flat or graded ? Or should they be on a percentage basis being related to the wages of the workers, should there be two separate classes of workers under (a) contributing, and (b) non-contributing ? In that case, what should be the contribution of the Employers for the two classes ? What should be the method and agency for collection of the contributions ?

4. *Cash Benefits.*—What should be the extent and duration of cash benefits ? Should they be flat or graded or based upon a percentage of the wages ?

5. *Medical Benefits.*—What should be the extent, nature, and duration of the medical benefits ? Should such benefits be also provided for the dependants of the insured ?

6. *Conditions for Receiving Benefits.*—For receiving the cash and medical benefits, what should be (a) the qualifying period, (b) the waiting period, (c) residential and other restrictions, if any ? What should be the kinds of illnesses covered ? Should incapacity or illnesses arising out of accidents or industrial diseases be covered for medical benefits ?

7. *Machinery for Medical Benefits.*—What should be the machinery for extending medical benefits to the workers ? Do you favour a " Panel System " of any other system of contracts between the Insurance Institution and medical associations or individual medical practitioners ? Or, would you prefer a whole-time or part time Medical Service, specially created for the purpose ? In either case, who should be the controlling authority for the medical machinery erected ?

8. *Maternity Benefits.*—Would you like Maternity Benefit to be brought under Sickness Insurance ? If so, state your reasons. What will be the approximate financial liability of this to the Fund ? In the event of Maternity Benefit being included under the Scheme, should the benefit be made available to (a) the insured person's wife, or only to (b) the female worker, married or unmarried ?

9 *Funeral Benefits.*—Are you in favour of giving a Funeral Benefit to the family in the event of the insured's death ? If so, what, in your opinion, should be the extent and nature of such benefit ? What will be the approximate liability of this benefit to the Fund ?

10. *Malingering and Collusion.*—What are the possibilities of Malingering ? How would you provide against them ? What are the possibilities of collusion between doctor and worker, or between employer and worker or between employer and doctor ? What steps would you suggest for preventing any leakages from the Fund on this account ?

11. *Financial Organisation.*—Should there be separate Funds for each industry ? What other features would you suggest for the financial machinery to be erected ?

12. *Administrative Machinery.*—What should be the Machinery of administration ? Should the benefits and contributions be administered through (a) Local Bodies, (b) Trade Unions, (c) Special bodies, created for this purpose, or (d) any other bodies ?

13 *Sickness Incidence among workers.*—Have you collected any figures showing the incidence of sickness among industrial workers for any group, or town, or factory ? What, do you think, could be regarded as a safe figure for the average number of days of sickness to which the industrial worker in your group, etc., is liable ?

14. *Workmen's Compensation.*—What are the possibilities if any of the Scheme overlapping with the provisions of the Workmen's Compensation Act, especially in regard to industrial diseases ?

15. *Settlements of Disputes.*— What should be the machinery for settlement of disputes arising between the Fund and the Workers, or the Fund and the employers or doctors and workers, etc. ?

II.—*Medical*

A note and a brief Questionnaire on the Problem of Medical Machinery for sickness Insurance of Industrial Workers in India.

The Government of India in the Labour Department have undertaken to prepare a preliminary scheme to serve as a basis for discussion with a view to the introduction of legislation to provide for Sickness Insurance for industrial workers in some of the major industries of India. A Sickness Insurance scheme ordinarily envisages to types of sickness benefits two the workers : firstly, a cash benefit consisting of a lump sum payment, depending upon the duration of the illness ; and secondly, a medical benefit, including medical attendance, pharmaceutical and hospital treatment. One of the most important questions arising in this connection is that of the constitution of the appropriate medical machinery for provision of medical benefit.

2. Two main systems prevalent in other countries are (a) the Panel System and (b) the Medical Service System. Both the systems have their advantages and disadvantages. The panel System recognises the worker's right to choose his own doctor and at the same time enables any member of the medical fraternity to apply for recognition as a panel doctor. On the other hand, the Panel System is mostly based upon individual practice, and as a single doctor cannot be expected under modern conditions to possess either the necessary equipment or the expert knowledge to deal with diseases in a comprehensive manner, the inevitable consequence is that for difficult or specialised cases, the patient has to be sent to a series of specialists. This defect is removed under the system of a regular medical service providing treatment in unified hospitals, where " group practice " is possible. Modern methods of diagnosis and treatment require an extensive and costly equipment of which only a group of doctors practising at the same centre can economically avail themselves : medical supplies, auxiliary staff, and overhead charges are likewise relatively cheaper for several doctors working together. The representation of different specialists within the group of physicians enables the diagnosis to be settled and the treatment to be prescribed efficiently and without loss of time for doctor or patient. Group organisation enables doctors to maintain one another's morale and to afford one another opportunities for further study and for leisure. But there is also the question of certification. It is natural that the worker should choose a doctor who is known to be rather lenient in giving certificates of illness. As both cash and medical benefits depend upon certification, this is a matter of great importance to the solvency of the Sickness Insurance Fund. Under the system of Medical Service, not only will the doctors be under the direct control and supervision of the Fund, but also the possibilities of false certification will be minimised owing to the better morale to be found under " group practice ".

3. Moreover, the Panel System tends to favour successful medical practitioners and the new-comers are comparatively worse off. In the present state of the medical profession in which there is considerable stagnation and crowding, it may not be fair to open up new lines of practice for successful doctors to expand their practice. If the Medical Service System is adopted it may be possible to employ several thousands of struggling medicos, thus bringing good to both the workers and the medical profession. However, the Panel System has worked fairly well in some countries, while in others it has given rise to a series of evils.

4. This question must also be viewed from another angle. The exigencies of the present War have necessitated the employment of large numbers of medical men on a temporary basis. When the War is over, the problem is bound to arise as to how the demobilised medicos should be reemployed. Sickness Insurance scheme, which in the first instance will be applicable to a few industries, may provide possible employment on a full-time basis for some of these demobilised medicos.

5. The Government of India have appointed me as Officer on Special Duty to investigate the entire question of Sickness Insurance. I have not yet formed any definite conclusions in regard to the choice of a particular system which would be suitable for India and I keep an open mind on this question. Before any final decision is taken, however, your opinion on this question will be welcome. I shall be grateful if you will kindly let me have your replies to the accompanying Questionnaire, and any notes or memoranda pertaining thereto, at the following address, not later than the 15th of June, 1943 :

Officer on Special Duty, Sickness Insurance, Council Hall, Bombay (1).

B. P. ADARKAR,
Officer on Special Duty, Sickness Insurance.

Questionnaire

1. Which of the two systems, *viz.*, the Panel System or the Medical Service System do you prefer for Sickness Insurance in India ? Please state reasons for your preference.

2. If you prefer the Panel System, should there be a standing contract between the Medical Associations and the Authorities of the Fund ? If so, what should be the form of the contract ?

3. If you prefer the Panel System, what should be the mode of payment ? Should payment be by way of (a) a fee per insured person, or (b) a fee per case of sickness, or (c) any other basis ?

4. If you prefer the Medical Service System, please state whether the doctor should be employed on whole-time or part-time basis ? What do you think should be the scales of pay ? What should be the basis of selection of doctors for the Medical Service ?

5. Will it be possible to provide medical treatment in existing hospitals in the various industrial centres, if the Fund attaches its medical men to such hospitals and also share some of their expenses ?

6. Who should control and supervise the Medical Section of the Fund at the various centres and what special precautions should be taken to prevent any leakages from the Fund ?

7. What should be the method of certification ? In particular, how would you prevent false certification?

8. Have you had any special experience of existing Sickness Insurance schemes in any factory or concern ? If so, kindly give all possible information relating to it.

III.—*Statistical.*

Questionnaire regarding Statistics of Sickness Incidence among Industrial Workers.

[*N.B.*—Kindly furnish figures in the form of tables given below as fully as possible. If detailed figures are not available, at least "totals" may be given in each case. The period to which the figures relate should be a "normal" year, *i.e.*, one free from epidemics, etc. If a shorter or a longer period is chosen, please state the exact length of the period and the dates or years.

Please send your replies to B. P. Adarkar, Esq., M.A. (Cantab.), Officer on Special Duty, Sickness Insurance, Government of India, Council Hall, Bombay, (1), so as to reach him not later than.....]

(1) Please describe in detail the system of Sickness Insurance or medical benefit adopted in your concern or factory. If you have any printed information or annual reports regarding the working of your Insurance or medical scheme, kindly send copies.

(2) Please give figures as in Table I, II and III below :—

Table I

Total Number of Persons covered.

Age	Males	Females
Below 16 ..		
16—20 ..		
21—25 ..		
26—30 ..		
31—35 ..		
36—40 ..		
41—45 ..		
46—50 ..		
51—55 ..		
Above 55 ..		
Total ..		

At what age do the workers generally make their entry into the scheme ? Also at that age do the workers generally enter employment in your factory or concern ?

Table II

Total Number of Sick Persons and Days lost in Sickness.

Age	Male.	Man-days lost.	Female.	Woman-days lost.
Below 16 ..				
16—20 ..				
21—25 ..				
26—30 ..				
31—35 ..				
36—40 ..				
41—45 ..				
46—50 ..				
51—55 ..				
Above 55 ..				
Total ..				

Table III

Nature of Illness.

Kind of Illness	No. of Sick Persons		Total Days lost	
	Males	Females	Man-days	Woman-days

(3) If you have any night shifts in your factory or concern, please state whether the incidence of sickness is higher in the case of night-shift workers. If so, by what percentage is it higher on the average ?

IV.—*Actuarial.*

[*Note.*—The Government of India in the Labour Department have appointed an Officer on Special Duty to draft a Scheme of Sickness Insurance for Industrial Workers. In this connection, the views of Actuaries are invited on the actuarial aspects of Sickness Insurance in India. Replies to the following Questionnaire, accompanied by any Memoranda of a general character, may be sent to Prof. B. P. Adarkar, O.S.D., Sickness Insurance, Council Hall, Bombay (1), so as to reach him not later than the 1st August 1943].

I. In view of the comparative lack of statistical data regarding age, incidence of sickness, the duration of employment of insurable workers, and their ages at entry and exit*, which of the two systems, *viz.*, the actuarial system and the assessment system, would you recommend in the case of India ? Please give reasons.

(*It may be mentioned here that in India the industrial workers have no fixed age for entry. They make their entry and exit at various ages.)

II. Do you think it would be feasible to adopt the assessment system for the first five years or so, during which period statistics will be collected by the Sickness Insurance Institution, and to make a change-over to the other system later on, if found necessary ?

III. What, in your opinion, are the reasons why practically all countries, except Great Britain and Ireland, have adopted the assessment system, not the other system, in the case of sickness insurance ?

IV. Is the case for the assessment system strengthened by the fact that a State Guarantee (in the shape of loans during deficit years to be repaid during surplus years) is available in the present case ?

V. Will you kindly suggest the kind of statistics which should be collected by the Sickness Insurance Institution when it is established, and, if possible, also the forms in which they should be collected ?

VI. If you would propose the assessment system, what method do you suggest for estimating the probable amount the State might have to lend under the Guarantee ? (At present, only the following statistics are available : a rough estimate of the total number of workers to be covered, a rough estimate of the average rate of sickness incidence per insured worker, the amount to be contributed per worker, and the extent of cash and medical benefits which will be given.)

VII. In view of the well-known tendency for the actual sickness experience to rise after introduction of a scheme involving cash benefit, how much " loading " or percentage allowance would you make over and above the initial figure of sickness incidence on this account ?

V.—*States—Special Questionnaire.*

[*Note.*—In view of the paucity of information regarding labour conditions in the Indian States, the following Questionnaire has been issued. Departments of Labour of the States are requested to collect such information as they can within as short a time as possible and forward it to B. P. Adarkar, Esq., M.A. (Cantab.), Officer on Special Duty, Sickness Insurance, Council Hall, Bombay (1), by the 15th August 1943. If necessary, further copies of this questionnaire may kindly be made and forwarded to industrial concerns, etc. Any printed material, including Annual or Special Reports and Blue Books relevant to labour conditions and legislation, if available, may also be sent separately or along with replies to this Questionnaire.]

1. To what extent is labour migratory in your State ? What is the approximate extent of British-Indian labour employed in factories in your State ? To what extent does labour from State migrate to British India for employment ?

2. What percentage of the labour force employed in factories in your State may be regarded as permanent ? Is there any system of *badli* or substitute workers ? If so, who pays the *badli* worker ? Is there an " *badli* control " system in factories in your State ?

3. To what extent is labour employed through contractors and sub-contractors ? In what industries is such contract labour predominant ? Assuming that we hold the principal employer responsible for payment and collection of contributions, what difficulties, if any, do you foresee in this procedure in the special case of your State ?

4. Are there any night shifts in the factories ; if so, in what industries ?

5. To what extent is labour organised in trade unions in your State ?

6. What are the periods and time of wage payment ? Can you give some idea regarding the level of wages in the factories ? What percentage of workers in the factories may be regarded as earning a basic wage (*i.e.*, excluding bonuses, allowances, etc.) of 8 As. or more per day ? Have you any provision under the Factory Rules for the calculation of a daily rate for overtime in the case of piece-wage workers ?

7. What is the extent of medical facilities existing at present in your State in general and in the factories in particular ?

8. Have you adopted any Maternity Benefit legislation ? If so, how far has it been successful in achieving its aims ? In particular, has there been any complaint that the woman worker is dismissed in the early months of her pregnancy, or that the employer is averse to the employment of female workers ? In this connection, will you kindly supply figures showing the number of male and female workers employed in factories subject to the Maternity Benefit Act over a series of years commencing with the date of its introduction ?

VI.—*Supplementary (Medical).*

1. Do you regard the existing medical facilities provided by some of the employers to their workers adequate and satisfactory ? Please give full reasons for your views.

2. For what purpose or purposes are these medical facilities maintained by the employers ? Would it be a great loss to (a) employers, and (b) workers, if these facilities are discontinued ?

3. Would you like such facilities to be continued even after the Scheme of health insurance is put into operation ? If so, in what manner should they be brought into relation with the Scheme ? If not, what do you propose to do with them ? Please state your reasons for or objections to either course as fully as possible.

4. In view of the close connection between cash benefit, certification, and medical benefit, what precise machinery do you suggest for paying cash benefits if the medical benefits continue to be provided in such establishments as hitherto ?

APPENDIX V.—Lists of Officials, Associations and others who sent in Replies to Questionnaires or Memoranda.

I.—*General Questionnaire.*

1. Mr. W. H. Phillips, Chief Inspector of Factories, Bombay.
2. The Labour Commissioner, United Provinces, Cawnpore.
3. Dr. R. B. Gupta, M.A.Ph.D., I.O.S., Welfare Officer, Ordnance Factory, Lucknow.
4. The Director of Industries, Bombay.
5. The Commissioner of Labour, Bombay.
6. The Commissioner of Labour, Sind.
7. The Commissioner of Labour in Mysore, Bangalore.
8. The Commissioner of Labour, Madras.
9. The Commissioner of Labour, Bihar.
10. The Deputy Commissioner, Delhi.
11. The Commissioner of Labour, Central Provinces and Berar.
12. The Chief Inspector of Factories, Orissa.
13. The Director of Labour, Baroda.
14. The Secretary, Department of Industries, Commerce and Communications, Gwalior Governments, Gwalior.
15. The Director of Industries, Travancore.
16. The International Labour Office (from Montreal Office through the Indian Branch).
17. The C. P. and Berar Textile Workers' Federation, Nagpur.
18. The Bombay Port Trust, Bombay.
19. The Southern Indian Millowners' Association, Coimbatore.
20. The All-India Manufacturers' Organisation, Bombay.
21. The Chamber of Commerce, Bombay.
22. The National Union of Railwaymen of India and Burma, Bombay.
23. The Punjab Chamber of Commerce, New Delhi.
24. The Employers' Federation of Southern India, Madras.
25. The Maharashtra Chamber of Commerce, Bombay.
26. The Tata Workers' Union, Jamshedpur.
27. The Indian Merchants' Chamber, Bombay.
28. The Delhi Factory Owners' Federation, Delhi.
29. The *Insurance Herald*, Calcutta.
30. The President, Millowners' Association, Beawar.
31. The Nellimarla Jute Mill Workers' Union, Nellimarla.
32. The Karachi Chamber of Commerce, Karachi.
33. The Karachi Indian Merchants' Association, Karachi.
34. The Indian Federation of Labour, Bengal Committee, 3, Chandni Chowk Street, Calcutta.
35. The Ahmedabad Millowners' Association, Ahmedabad.
36. The Factory Owners' Association, Akola (Berar).
37. The All-India Trade Union Congress (Advisers : Messrs. S. C. Joshi and S. S. Mirajkar).
38. The Textile Labour Association, Ahmedabad.
39. The Bombay Engineering Employers' Federation, Bombay.
40. The Khandesh Millowners' Association, Dhulia.
41. The All-India Organisation of Industrial Employers, New Delhi (Advisers : Sir Shri Ram and Seth Kasturbhai Lalbhai).
42. The Bombay Presidency Women's Council, Bombay.
43. The Employers' Federation of India, Bombay (Adviser for Millowners' Association, Mr. J. C. Lancashire).
44. The Indian Jute Mills Association and The Indian Engineering Association, Calcutta (Advisers : Messrs. A. H. Bishop and G. M. Garrie).

45. The Merchants Chamber of United Provinces, Cawnpore.
46. The Bombay Medical Union, Bombay.
47. The Indian Federation of Labour, Bombay (Advisers : Messrs. V. M. Tarkunde and G. Lobo).
48. The Birla Cotton Spinning and Weaving Mills, Ltd., Delhi.
49. Mackinnon Mackenzie & Co., Bombay.
50. The Assam Oil Company, Ltd., Digboi.
51. Dadajee Dhackjee and Co., Bombay.
52. The Burmah-Shell Oil Storage and Distributing Company of India, Ltd., Bombay.
53. The Motilal Agarwal Mills, Gwalior.
54. The Tinplate Company of India, Golmuri.
55. The Jiyajeerao Cotton Mills, Ltd., Gwalior.
56. The Tata Iron and Steel Company, Ltd., Jamshedpur.
57. Mr. G. S. Diwan, F.I.A., Sydenham College of Commerce, Bombay.

II.—*Medical Questionnaires (Main and Supplementary).*

1. The Civil Surgeon, Ajmer-Merwara.
2. The Inspector General of Civil Hospitals, Assam.
3. The Inspector General of Civil Hospitals, Punjab.
4. The Surgeon General with the Government of Bombay, Bombay.
5. The Civil Surgeon, Sholapur.
6. The Deputy Commissioner, Ajmer-Merwara.
7. The Inspector of Factories, Delhi and Ajmer-Merwara.
8. The Inspector General of Civil Hospitals, United Provinces.
9. The Surgeon General, Bengal.
10. The Chief Inspector of Factories, Bengal.
11. The Certifying Surgeon of Factories, Calcutta.
12. The Inspector General of Civil Hospitals, Bihar.
13. The Inspector General of Civil Hospitals, Central Provinces and Berar.
14. The Chief Medical Officer, Delhi Province.
15. The Surgeon General with the Government of Madras, Madras.
16. Rao Saheb Dr. N. S. Narasimha Iyer, Othopædic Surgeon, General Hospital, Madras.
17. Dr. M. Gopala Kini, Superintendent, Stanley Hospital, Madras.
18. Dr. R. Mahadevan, Professor of Operative Surgery, Andhra Medical College, Waltair.
19. The Commissioner of Labour, Central Provinces and Berar.
20. Col. E. S. Phipson, Medical Officer of Health, Simla.
21. The Director of Health and Inspector General of Prisons, Orissa.
22. The Commissioner of Labour, Bihar.
23. The Chief of the Medical and Health Departments, Baroda State.
24. The Director of Public Health, United Provinces.
25. The Commissioner of Labour in Mysore, Bangalore.
26. The Director, Railway Board Department, Government of India.
27. The Secretary, Travancore Medical Association, Trivandrum.
28. The Registrar, Bengal Council of Medical Registration, Calcutta.
29. The Registrar, Bihar Council of Medical Registration, Patna.
30. The Indian Medical Association, Calcutta.
31. The Bombay Medical Union, Bombay.
32. The Delhi Cloth and General Mills Co., Ltd., Delhi.
33. The Tinplate Company of India, Ltd., Golmuri.
34. The Assam Oil Company, Ltd., Digboi.
35. The Pulgaon Cotton Mills, Pulgaon.
36. The Rai Saheb Rekhchand Mohota Spinning and Weaving Mills, Hinganghat (C.P.).
37. Dr. H. P. Dastur, Bombay.
38. Dr. A. S. Erulkar, Bombay.
39. Dr. F. N. A. Moos, Bombay.
40. Dr. G. K. Kulkarni, Congress Nagar, Nagpur.
41. Dr. S. Satyanarayana, Rayavaram, E. Godavari Dt.
42. Lt.-Col. S. J. Bhathena, Bombay.
43. Captain H. N. Shivapuri, Lucknow.
44. Dr. Hardes Singh Verva, Civil Hospital, Barant (Meerut).

III.—*Statistical Questionnaire.*

1. The Chief Inspector of Factories, Madras.
2. The Assam Oil Company, Ltd., Digboi.
3. The Madura Mills Company, Ltd., Madura.
4. Dr. R. B. Gupta, I.O.S., Welfare Officer, Ordnance Factories, Lucknow.
5. The Burmah-Shell Oil Storage and Distributing Company of India, Ltd., Bombay.
6. The Indian Copper Corporation, Ltd., Ghatsila.
7. Best and Company, Ltd. (Skins and Hides Department), Madras.
8. The Delhi Cloth and General Mills Company, Ltd., Delhi.
9. The Pratap Spinning, Weaving and Manufacturing Company, Ltd., Amalner.

10. The Swastik Oil Mills, Ltd., Wadala, Bombay.
11. The Gaya Sugar Mills, Ltd., Guraru Mills, P. O., Gaya.
12. The Savatram Ramprasad Mills Company, Ltd., Akola.
13. The Andhra Paper Mills Company, Ltd., Rajahmundry.
14. The East India Tramways Company, Ltd., Karachi.
15. The General Motors India, Ltd., Bombay.
16. The Sholapur Spinning and Weaving Company, Ltd., Sholapur.
17. The India Electric Works, Ltd., Calcutta.
18. The Hindustan Bicycle Manufacturing and Industrial Corporation, Ltd., Phulwari Shareef (Patna).
19. The Rajalakshmi Mills, Ltd., Uppilipalayam.
20. The New Satgram Coal Company, Ltd., Rajbari P. O., Burdwan Dt.
21. The Lakshmiratan Cotton Mills Company, Ltd., Cawnpore.
22. The Motilal Padampat Sugar Mills Company, Ltd., Majhaulia.
23. The Indian Hume Pipe Company, Ltd., Bombay.
24. The Navjivan Mills, Ltd., Kalol.
25. The Swastik Engineering and Manufacturing Company, Ltd., Savaji Ganj, Baroda.
26. The Birla Cotton Spinning and Weaving Mills, Ltd., Delhi.
27. The Tinplate Company of India, Ltd., Golmuri.
28. The Employers' Federation of Southern India, Madras.
29. Addison and Company, Ltd., Madras.
30. The Bangalore Woollen, Cotton and Silk Mills, Bangalore.
31. Binny and Company (Madras), Ltd., Engineering Department, Madras.
32. The Buckingham and Carnatic Mills, Madras.
33. Messrs. Parry and Company, Ltd., Madras.
34. Messrs. Spencer and Company, Ltd., Madras.
35. The Madras Electric Tramways, Ltd., Madras.
36. The Western India Watch Company, Ltd., Madras.
37. The Coimbatore Cement Works, Coimbatore.
38. The Kistna Cement Works, Bezwada.
39. The Cambodia Mills, Ltd., Coimbatore.
40. The Indian Leaf Tobacco Development Company, Ltd., Chirala.
41. The Mettur Industries, Ltd., Salem Dt.
42. The Mangalore Electric Supply Company, Ltd., Mangalore.
43. The Salem-Erode Electric Distribution Company, Ltd., Salem.
44. The Pankaja Mills, Ltd., Coimbatore.
45. The Vasanta Mills, Ltd., Coimbatore.
46. The Behar Sugar Works, Pachrukhi.
47. Jyoti Ltd., Baroda.
48. The Bombay Electric Supply and Tramways Company, Ltd., Bombay
49. The Sirpur Paper Mills, Ltd., Hyderabad (Dn.).
50. The Railway Department (Railway Board).
51. The Tata Iron and Steel Company, Ltd., Jamshedpur.
52. The Sayaji Jubilee Cotton and Jute Mills Company, Ltd., Sidhpur.
53. The Tata Iron and Steel Company, Ltd., Jamadoba, Manbhum Dt.
54. The Bata Shoe Company, Ltd., Batanagar.
55. The Tata Hydro-Electric Generating Stations, Jamshedpur.
56. The Burma Oil Company, Ltd., Masimpur.

IV.—*Actuarial Questionnaire.*

1. Mr. C. D. Sharp, F.I.A., Gresham Assurance House, Bombay.
2. Mr. H. P. Humphreys, F.I.A.
Mr. S. D. Srinivasan, F.I.A. } Joint reply.
National Insurance Company, Ltd., Calcutta.
3. Mr. P. R. Gupta, M.A., F.C.I.I. (Lond.), Calcutta.
4. Mr. R. Cubie, F.F.A., Hindustan Co-operative Insurance Society, Ltd., Calcutta.
5. Mr. G. S. Diwan, F.I.A., Sydenham College of Commerce, Bombay.
6. Mr. K. Y. Joshi, A.I.A., Western India Life Insurance Company, Ltd., Safara City.
7. Mr. D. S. Subrahmaniam, M.A., A.I.A., F.S.S., Masulipatam.
8. Mr. L. S. Vaidayanathan, M.A., F.I.A., Oriental Government Security Life Assurance Company, Ltd., Bombay.
9. Mr. V. L. Sapre, A.I.A., The Jupiter General Insurance Company, Ltd., Bombay.

V.—*Special Questionnaire (Indian States).*

1. The Commissioner of Labour in Mysore, Bangalore.
2. The Labour Officer, H. E. H. The Nizam's Government, Hyderabad.
3. The Director of Labour, Baroda.
4. The Inspector of Factories, Holkar State, Indore.
5. The Secretary, Department of Industries Commerce and Communications, Gwalior.
6. The Director of Industries, Travancore.

APPENDIX VI.—STATISTICAL AND OTHER RELEVANT INFORMATION COLLECTED IN RELATION TO SICKNESS INCIDENCE.

In this Appendix the available statistical and factual material relating to sickness incidence has been presented in a summary form. Admittedly the quality of the data collected is not of a high order and it is unnecessary to vouchsafe the accuracy of the figures. Yet, for what they are worth, the figures do indicate a certain level of sickness incidence, which may provide guidance to us. [In particular, attention is drawn to the figures supplied by the Assam Oil Co. (Tables 1-a and 1-b), whose cash and medical benefits exactly correspond to the benefits proposed in the present Scheme, as also those supplied by the Madura Mills (Table 4), the Delhi Cloth Mills (Table 5), Lyallpur Cotton Mills (Table 6), the Buckingham & Carnatic Mills (Table 7), the Bangalore Woolen, Cotton and Silk Mills (Table 8). The Railway Table (Table 12) also is instructive.]

TABLE 1 (*a*).—*Assam Oil Company Ltd., Digboi*, 1942.

Age	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Under 16 years	12	51	405	33·75	8·0	..	..	..	..	..
Over 16 years	7,997	13,051	80,468½	10·06	6·2	31	29	259	8·36	8·9
Total ..	8,009	13,102	80,873½	10·09	6·2	31	29	259	8·36	8·9

TABLE 1 (*b*).—*Assam Oil Company Ltd., Digboi*, 1943.*

Age	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Below 16	12	6	20½	6·83	3·4	..	..	..	..	..
16—20 ..	376	200	983½	10·46	4·9	1	..	..	..	..
21—25 ..	2,023	990	4,369½	10·62	5·4	13	3	12	3·7	4
26—30 ..	2,148	927	4,629½	10·48	6·1	6	1	20	13·33	20
31—35 ..	1,421	515	3,573	10·05	6·9	3	..	..	..	..
36—40 ..	1,165	407	3,560½	8·79	6·3	6	..	..	..	..
41—45 ..	596	176	1,454	9·76	8·2	2	..	..	..	..
46—50 ..	196	63	503½	10·28	8·0	..	..	..	..	..
51—55 ..	57	14	94½	6·63	6·8	..	..	..	..	..
Over 55	15	1	2	0·5	2·0	..	..	..	..	..
Total ..	8,009	3,299	20,190½	10·08	6·1	31	4	32	4·13	8·0

All employees and their direct dependents are given free medical treatment and advice. A modern equipped hospital and a highly qualified staff are provided. Maternity treatment and advice are provided free for wives of employees. All employees from the date of engagement qualify for free medical treatment.

During periods of sickness employees are paid half pay for the first four days and full pay and allowances thereafter up to a total of 90 days in a year.

*Figures are given for the first quarter of 1943. The incidence of sickness per year has been worked out after multiplying the figures by 4.

Cash benefit was actually paid for the man-days and woman-days last mentioned in the table. The rate of incidence of sickness is, therefore, net.

TABLE 2.—*Indian Copper Corporation Ltd., Ghatsila*, 1940.

Works	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Mosaboni Mines ..	3,276	12,018	36,353	11·09	3·0	320	173	2,997	9·37	17·3
Moubhandar Works	1,429	6,820	9,767	6·83	1·4	159	113	863	5·43	7·6

The rate of incidence of sickness is gross.

There is a Sickness Benefit Scheme in the Mines area. The operation of the Scheme in the Works area was stultified by the introduction of the Payment of Wages Act which prevented deductions from wages being made. The Scheme covers two separate matters, sickness and injury. The following are the workers' contributions :—

Wages 6 annas or less per day	No contribution.
over 6 as. and up to 10 as. per day	2 as. per month.
over 10 as. and up to Re. 1 per day	3 as. per month.
over Re. 1 per day	4 as. per month.

Every worker when certified as ill by the Company's Medical Officer receives the following benefits :—

For the first three days no benefit except free medical attention and medicines. After that half pay until such time as he is declared fit to resume his duties. If an in-patient, subsistence allowance is given as an advance on sick pay if required.

All employees at the Mines and the works with their wives and children receive treatment in the Company's two hospitals.

TABLE 3.—*East India Tramways Co. Ltd., Karachi.*

Number of workers	Number of days lost due to sickness	Average incidence of sickness (days per year)
400	1,080	2·70

A contribution of one pie in the rupee is made by every employee and officer from his salary towards the sickness benefit scheme. Cash benefit is given at the following rates :—

Amount of salary	For three months from date of sickness	For further one and a half months
Rs. 0—30	50% of salary	25%
30—40	40% ,,	20%
40—80	30% ,,	15%
80—100 or more	20% ,,	10%

No payment is made unless an employee is off work 7 days or more.

Other benefits such as funeral grants, Railways fares to those proceeding on sick leave, etc., are also granted.

Medical benefits include special patent medicines and surgical appliances (except spectacles) which are provided from the Society's funds.

TABLE 4.—*Madura Mills Company Ltd., Madure*, 1942

Mills	Number of Man-days on Rolls	Number of Man-days lost due to sickness	Average incidence of sickness (days per year)
Madura	31,41,334	1,32,130	13·1
Pandyan (Madura East)	4,95,196	15,946	12·1
Tuticorin	13,84,785	63,309	14·0
Ambasamudram	20,19,032	95,887	14·6
Total ..	70,40,347	3,80,272	13·6

The rate of incidence of sickness is gross.

Sick leave with pay up to 7 days in the year and Quarantine wages up to a maximum of 30 days at a stretch are given to workers.

After the completion of one year's continuous service operatives will be entitled to (*a*) 6 days leave per annum on full pay and (*b*) 7 days leave per annum on full pay on medical certificate.

Operatives granted Quarantine wages, whether as sufferers or as contacts, will be considered to have been given sick leave with pay for the proportionate period :—

(*a*) Sufferers will be granted full wages up to a maximum of 30 days provided they have put in one year's service and provided they have not been absent for 16 or more days at a stretch during the one year period.

(*b*) Contacts will be allowed half wages up to a maximum of 30 days provided they have put in three years' service and provided they have not been absent for 15 or more days at a stretch any time during the three-year period.

Operatives on piece rate will be allowed a fixed rate of 8 annas per day for the days they are entitled to privilege or sick leave.

Medical benefit.—A well equipped Dispensary in the Mill compound under the charge of a fully qualified Doctor and a separate Dispensary for females and children under the charge of a Lady Doctor are maintained.

Cases requiring hospitalization are sent for treatment at Company's cost to the Willis F. Pierce Memorial Hospital, Madura, to whom the Company pay monthly and half-yearly contributions in addition to paying cost of medicine, diet, etc. Wages in full or part are allowed to workers sent to hospital according to merit.

TABLE 5.—*Delhi Cloth Mills.*

Year	Total number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
1941	4,143	1,837	8,550	2·06	4·6
1942	10,520	3,572	51,859	4·93	14·5

TABLE 6.—*Lyallpur Cotton Mills.*

Year	Total number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
1941-42	4,044	729	6,587	1·63	9·0
1942-43 (for 9 months) ..	4,602	760	6,762	1·96*	8·9

* Incidence of sickness calculated for one year.

The rate of incidence of sickness is net, being worked out from the number of man-days lost for which cash benefit was actually given.

Contributions for the Sickness Benefit Scheme are collected from the workers at a flat rate of one anna per month. The cash benefit becomes payable on the seventh day of morbidity and the maximum period for which it is allowed is 3 months in the Delhi Cloth Mills and 6 weeks in the Lyallpur Cotton Mills. The amount of benefit is Rs. 2 per week at Delhi and Rs. 3 per week at Lyallpur. Since 1st June 1943 the workers' contribution has been raised to two annas per month and the corresponding cash benefit increased to Rs. 16 per month.

The medical benefits include free medicines, pharmaceuticals and appliances and free hospitalisation.

TABLE 7.—*Buckingham and Carnatic Mills, Madras.*

Total number of workers	Number of days lost due to sickness	Average incidence of sickness (days per year)
8,040	70,183	8·73

The rate of incidence of sickness is gross, the number of days lost due to sickness being irrespective of whether cash benefit or sick leave with pay was given. The net rate of incidence of sickness is, however, 3·50.

Sick leave on "compassionate allowance" is granted at the discretion of the Manager on recommendation by the Mills' Medical Officer. The conditions for receiving relief are that sickness should exceed three days continuously, that the employee's previous record should be satisfactory to the Manager and that the application must be supported by a certificate from the Company's Medical Officer who will not grant certificates in cases of sickness which, in his opinion, have been caused by misconduct or neglect.

Relief will be given for a period of 20 working days yearly at the following rates :—

Pay	Allowance (Relief
Over Re. 1 per day	10 annas.
12 as. to Re. 1 per day	8 ,,
10 as. to 12 as. per day	6 ,,
Below 10 as. per day	4 ,,

Medicines and medical advice are given free to all Mill employees and their families.

TABLE 8.—*Bangalore Woollen Cotton and Silk Mills, Bangalore.*

Male					Female				
Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
6,186	2,384	16,495	2·67	6·9	461	136	980	2·12	7·2

Sick leave on half average pay is granted at the discretion of the Manager on recommendation by the Mills' Medical Officer subject to a maximum of three months in a year. Special cases are considered by the Mill Manager according to their merits.

Medicines and medical advice are given free to all Mill employees and their families. There is also an in-patient ward in the Mill Dispensary with five beds for use of cases suffering from minor ailments.

A workman is etitled to medical benefit from the date of entertainment to the date of discharge.

TABLE 9.—*The Andhra Paper Mills Co. Ltd., Rajahmundry.*

Age	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Below 16	1	1	15	15·0	15·0	..	..	..	..	..
16—20	45	14	224	5·0	16·0	2	1	30	15·0	30·0
21—25	80	26	260	3·25	10·0	8	2	30	3·75	15·0
26—30	100	30	270	2·70	9·0	20	4	120	6·00	30·0
31—35	130	50	500	3·87	10·0	30	5	50	1·67	10·0
36—40	75	20	240	3·20	12·0	25	4	40	1·60	10·0
41—45	70	20	300	4·29	15·0	20	3	24	1·20	8·0
46—50	50	18	180	3·60	10·0	15	2	14	0·93	7·0
51—55	37	10	100	2·70	10·0	4	1	8	2·0	8·0
Above 55	3	1	90	30·0	90·0	1	..	..	..	..
Total ..	591	190	2,179	3·68	11·5	125	22	316	2·54	14·4

The number of man-days and woman-days lost due to sickness relate to the days for which sick leave with pay was given to the workers on production of medical certificate. The rate of incidence of sickness is, therefore, net.

Sick leave on full pay is granted for 7 days per year to all workers after completion of one year's service provided thay have worked 90 per cent of the working days in the year.

Free medical treatment is given to all mill wokers. The factory doctor also visits sick persons at their house if he is unable to go the the Dispensary.

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TABLE 10—*Lakshmiratan Cotton Mills Co. Ltd., Cawnpore.*

Age	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Below 16	..	..	..	..	..	..	..	..	..	..
16—20	185	..	124	0·67	..	5	..	..	..	..
21—25	555	..	500	0·90	..	3	..	16	5·33	..
26—30	740	..	2,008	2·71	..	8	..	36	4·50	..
31—35	740	..	2,152	2·91	..	10	..	20	2·00	..
36—40	555	..	2,376	4·28	..	14	..	12	0·86	..
41—45	370	..	264	0·71	..	5	..	..	..	..
46—50	370	..	40	0·11	..	3	..	..	..	..
51—55	148	..	68	0·46	..	..	..	..	..	..
Above 55	37	..	28	0·76	..	..	..	..	..	..
Total ..	3,700	..	7,560	2·04	..	48	..	84	1·75	..

The rate of incidence of sickness is gross as there is no system of cash benefit or sick leave with pay.

Free medical attendance is provided for the workers under a qualified Medical Officer. In deserving cases free injections and patent medicines are also allowed. In urgent cases free medical attendance is provided to the workers at their residence.

TABLE 11.—*Tinplate Co. of India Ltd., Golmuri.*

Age	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Below 16	2	2	22	11·00	11·0	1	..	..	..	..
16—20	156	15	100	0·64	6·7	17	10	98	7·76	9·8
21—25	635	207	2,452	3·86	11·8	25	25	304	12·16	12·2
26—30	565	403	5,692	10·07	14·1	21	32	795	37·86	24·9
31—35	695	409	5,565	8·01	13·6	28	18	229	8·18	12·7
36—40	640	496	8,206	12·82	16·5	21	10	134	6·38	13·4
41—45	409	356	6,004	14·68	16·8	13	12	258	19·85	21·5
46—50	215	136	2,185	10·16	16·1	6	2	23	3·83	11·5
51—55	71	25	743	10·46	29·7	4	1	12	3·00	12·0
Above 55	26	14	123	4·73	8·9	1	1	36	36·00	36·0
Total ..	3,414	2,063	31,092	9·11	15·1	137	111	1,889	13·80	17·0

The rate of sickness incidence is gross, being worked out from the total number of days the workpeople were permitted to be absent from work on account of sickness.

Sick leave on full pay is granted for 5 days per annum but employees are allowed to utilise their 15 days' privilege leave on full pay per annum, against sick leave if necessary. Provided, therefore, that no privilege leave has been taken the maximum sick leave allowable on full pay is 20 days per annum. Employees are granted reasonable long sick leave on no pay, provided the sickness is supported by a valid medical certificate.

The Company has a fully equipped hospital with 8 beds under the supervision of two qualified doctors and staff. The employees and their families receive free treatment, medicine and accommodation. Serious cases requiring special treatment are sent to the Tata's Main Hospital where treatment of the employees, if recommended by the Company, is also given free.

There are no age-limits or income limits for receiving sick pay or medical treatment. Free medical treatment is granted from the start of an employee's service but sick leave on full pay is only granted after one year's service.

TABLE 12.—*The Bata Shoe Co., Ltd., Batanagar.*

Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness.
6,815	33,813	55,200	8·10	1·6

All employees of the Company are eligible to become members of the Bata Workers' Sickness Benefit Society. The members contribute towards the Fund of the Society according to their salaries on the following scale :—

Salary Rs. 7 or less per week—No contribution.

Above Rs. 7 up to Rs. 10 per week—1 anna.
Rs. 10 up to Rs. 15 per week—3 annas.
Rs. 15 up to Rs. 20 per week—4 annas.
Rs. 20 up to Rs. 29/15 per week—8 annas.
Rs. 29/15 and above per week—Re. 1.

The Company also contribute an equivalent amount.

In case of sickness, members, as well as their wives and children, are entitled to free medical treatment including the supply of medicines other than proprietory and patent. For serious illnesses they are also entitled to medical attendance at their own residence. To members who have completed one year's continuous service under the Company, a cash benefit of half the average wage, up to a maximum of 14 days in the year, is also given at the Society's discretion.

TABLE 13.—*The Tata Iron and Steel Co., Ltd., Jamshedpur.*

Year	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness.
1941-42	190,641	6·52	12·6
1942-43	220,933	7·04	12·3

The incidence of sickness given above is the gross rate, the number of man days lost being the total number of days the workpeople were permitted to be absent on account of sickness, irrespective of sick leave with pay.

The employees are not given sick leave as such. But they are given privilege and other kinds of leave as follows :—

Monthly-rated staff :—30 days privilege leave for every completed year of service, 5 days casual leave and 2 days festival leave. Also for employees getting Rs. 30 and over per mensum, 6 months furlough leave on half-pay or 3 months on full pay for every period of 7 years' continuous service.

Daily-rated staff :—14 days privilege leave for every completed year of service and 2 days festival leave.

The weekly paid labour do not get any leave with pay; they are given attendance bonus of 2 days' additional pay for every 4 weeks of duty, provided the employee had not been absent for more than one day during the period, and one day's additional pay if he was not absent for more than 2 days. Generally, employees avail of the privilege leave to cover periods of sickness or for the purpose of recuperation. The Company has constructed and maintains at Jamshedpur a large and well-equipped hospital with a qualified and competent staff. At the hospital, both out-door and in-door treatment is given free to all employees and, in the case of employees whose emoluments do not exceed Rs. 250 p.m., to their families as well. All employees are entitled to gratuitous attendance from the Company's Medical Officers at their houses in cases where the illness confines them to bed. The attending Medical Officer shall be the judge whether an employee should be treated at his house. But an employee has the right to appeal to the Chief Medical Officer whose decision shall be final. The Company's Medical Officers shall be entitled to charge fees up to a fixed maximum for attendance on the members of the employee's family at his house.

TABLE 14.—*The Burmah Oil Company Ltd., Masimpur.*

Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year)	Average duration of illness.
365	529	2,441·5	6·69	4·6

Sick leave with pay was given for all the men-days lost on account of sickness. The rate of incidence of sickness is, therefore, *net*. Sick leave with half-pay is given for the first 4 days of each period of sickness ; and thereafter full pay is given. The maximum period for which sick pay is normally paid in any one year is 90 days, including all periods of half-pay and full pay. Special illnesses (e.g. tuberculosis, leprosy, etc.), may receive special consideration. Free medical treatment is given to employees and at the principal centres of the Company's operations the Company maintains its own staff and hospitals.

TABLE 15.—*The Rajalakshmi Mills, Ltd., Uppilipalayan (Coimbatore).* 1942.

Age	Male			Female		
	Number of workers.	Total number of days lost in sickness	Average incidence of sickness (days per year)	Number of workers.	Total number of days lost in sickness	Average incidence of sickness days per year)
Below 16	..	..	..	..	..	..
16—20	366	2,488	6·80	128	1,210	9·45
21—25	278	2,960	10·65	89	875	9·83
26—30	129	1,377	10·67	64	574	8·97
31—35	62	708	11·42	37	338	9·13
36—40	38	453	11·92	23	182	7·91
41—45	31	312	10·06	14	141	10·07
46—50	12	118	9·83	5	82	16·40
51—55	12	138	11·50	..	..	..
Above 55	..	..	..	..	..	..
Totals and averages ..	928	8,554	9·22	360	3,402	9·45

Ten days' sick leave is granted with full pay to all workers irrespective of age or sex. A resident compounder attends to the needs of all sick workers throughout the day. The mill doctor visits the mills once in a week and attends to serious cases. Sick leave with pay is granted by the mill compounder daily after examining individual cases at the mill premises. Cases where the sick workers are unable to go over to the mills, are considered by the Manager and sick leave with pay is granted.

TABLE 16.—*The Tata Iron and Steel Company (Colliery Department). 1942-43.*

Colliery.	Male					Female				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness
Jamadoba	2,478	5,801	12,602	5·09	2·2	216	1,139	471	2·18	0·4
Digwadih	2,362	3,047	18,282	7·74	6·0	17	557	445	2·60	0·8
Malkera-Choitodih	2,092	1,552	11,966	5·73	7·7	248	80	593	2·39	7·4
Sigua	2,002	1,277	9,673	4·83	7·6	981	112	946	0·96	8·4

The incidence of sickness given is the *gross* rate. Weekly paid staff get a sustenance allowance of 4 annas per day during the sick period. Quarantine leave is granted to staff in cases of infectious diseases. Privilege leave with full pay for one month is granted to all officers and for 22 days to all subordinate monthly-paid staff. Free medical attendance and free medicines are supplied to labourers, their families and relatives.

TABLE 17.—*The Tata Hydro-Electric Generating Stations. 1942-43*

Station	Skilled workes			Unskilled workers			Total.		
	Number of workers	Total number of days lost in sickness	Average incidence of sickness (days per year)	Number of workers	Total number of days lost in sickness	Average incidence of sickness (days per year)	Number of workers	Total number of days lost in sickness	Average incidence of sickness (days per year)
Khopoli ..	17	114	6·71	114	251	2·20	131	365	2·79
Bhivpuri ..	17	176·5	10·38	136	668	4·95	152	844·5	5·56
Bhira	18	130	7·22	230	173	0·75	248	303	1·22

Sick leave with pay is liberally granted to deserving cases. At each station there is a fully equipped Dispensary in charge of a qualified, resident doctor, giving free treatment to the workman and all his dependants. Attention is also devoted to the employees' living and working conditions. The sanitation of the camp, the housing of the workman, his food—all receive attention. Even his entertainment is thought of and he is provided with a club with indoor and outdoor games.

TABLE 18.—*The Madras Electric Tramways Co., Ltd.*

Age	Male				
	Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness.
Below 16	..	..	..	..	..
16—20	9	1	3	0·33	3·0
21—25	62	12	72	1·16	6·0
26—30	58	17	133	2·30	7·8
31—35	62	23	277	4·47	12·0
36—40	77	19	215	2·79	11·3
41—45	32	4	46	1·44	11·5
46—50	30	10	177	5·90	17·7
51—55	8	3	36	4·50	12·0
Above 55	2	..	..	..	..
Total ..	340	89	959	2·82	10·8

The incidence of sickness is the *gross* rate, as all sick leave to daily paid workers is on loss of pay. In order to obtain sick leave the employee has to report to the Company's Medical Officer who sanctions the leave required. Monthly paid employees such as clerical staff, foremen, etc., are granted sick leave on full pay. Employees suffering from small-pox, chicken-pox or cholera or employees who are forbidden by the Health Officer to attend their work are given quarantine leave pay at the following rates :—

8 annas per day to employees earning under 12 as. per day and 12 as. per day to employees earning over 12 annas per day.

Employees reporting themselves sick at the Medical Office are examined by the doctor who gives them free medical treatment including medicines until their recovery. No free medical treatment is given to relatives of employees. Medical treatment is given free to all employees irrespective of age or income.

TABLE 19.—*Cambodia Mills, Coimbatore.*

Male					Female				
Number of workers	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness.	Number of workers	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness.
1,657	6,156	11,446	6·91	1·8	583	2,608	4,584	7·86	1·7

A period of 7 days sick leave with pay is given to all operatives who have completed one full year's service with 90 per cent. minimum attendance for the year. All minor and major diseases are treated by the doctor and compounder in the Mill Dispensary. In case of accidents which cannot be attended to at the Dispensary, arrangements are made with the Headquarters Hospital for treatment. Medical treatment is administered to persons irrespective of considerations of service.

TABLE 20.— *The Salem-Erode Electric Distribution Co.*

Age.	Male.				
	Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year.)	Average duration of illness.
Below 16	..	..	..	..	..
16—20	2	..	..	..	..
21—25	16	7	104	6·50	14·8
26—30	31	20	246	7·94	12·3
31—35	31	16	269	8·68	16·8
36—40	26	12	180	6·92	15·0
41—45	11	9	107	9·72	11·9
46—50	9	4	93	10·33	23·2
51—55	1	1	30	30·00	30·0
Above 55	1	..	..	..	..
Total ..	128	69	1,029	8·04	14·9

Sick leave up to one month with full pay and up to a further 15 days with half-pay will be granted per annum, provided a certificate is produced from the doctor designated by the Company stating that the employee by reason of his illness, is unable to perform his duties. If the employee is on leave outside his station and falls ill, similar rules apply, provided a certificate is produced from a registered Medical Practitioner. Leave without pay in continuation of leave with pay will not be permitted except in cases of duly certified illness. In view of the relatively small number of workmen employed, the whole-time services of a Medical Officer are not availed of, but a retaining fee is paid to a Medical Officer who is responsible for giving full attention to the workers.

TABLE 21. *Railway Department (Railway Board).*

Statement of Medical Statistics of Subordinate Staff on Class I Indian Railways and Colliery Staff under the Chief Mining Engineer.

Railways.	Year.	Subordinates drawing Rs. 250 p.m. or over on scales of pay rising to Rs. 250 p. m. or over			On scales of pay rising to Rs. 30 p.m. or above but below Rs. 250 p.m.			On scales of pay below Rs. 30 p.m.			Daily rated labour and inferior staff			Total.		
		Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in year)	Strength of Staff.	Number of sick days leave granted	Sickness incidence per the worker (days in year)	Strength of Staff.	Number of sick days leave granted	Sickness incidence per the worker (days in year)	Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in year)	Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in year)
Assam Bengal	1939	109	414	3·80	3,632	34,782	9·58	289	4,514	15·62	12,521	65,529	5·23	16,551	105,239	6·39
	1940	111	408	3·67	3,603	39,700	11·02	95	1,195	12·57	12,587	72,994	5·79	16,396	114,297	6·97
Bengal and North Western	1939	118	424	3·60	4,517	19,903	4·41	996	2,842	2·85	22,843	40,912	1·79	28,474	64,081	2·25
	1940	122	557	4·56	4,605	23,772	5·16	1,019	3,936	3·86	22,774	43,592	1·91	28,520	71,857	2·52
Bengal Nagpur	1939	848	3,371	3·97	9,886	143,925	14·55	*Nil*	*Nil*	*Nil*	58,876	376,645	6·39	69,610	523,941	7·52
	1940	858	2,409	2·81	10,136	152,188	15·01	*Nil*	*Nil*	*Nil*	57,644	427,867	7·42	68,638	582,464	8·48
Bombay Baroda and Central India ..	1939	943	8,166	8·66	18,288	178,424	9·75	1,370	20,432	21·58	42,062	185,233	4·40	62,663	401,255	6·40
	1940	939	6,712	7·14	18,072	188,043	10·40	1,351	21,782	16·12	42,223	188,703	4·47	62,585	405,240	6·47
Eastern Bengal	1939	409	2,546	6·22	9,156	125,477	13·70	1,049	11,253	10·73	43,458	222,329	5·11	54,072	361,605	6·69
	1940	409	2,071	5·06	9,325	111,261	11·93	1,070	10,348	9·68	42,038	214,217	5·09	52,842	337,897	6·39
East India	1939	1,864	17,104	9·18	21,643	273,758	12·64	44	*Nil*	*Nil*	106,684	480,731	4·50	130,235	771,593	5·95
	1940	1,847	17,944	9·71	22,023	273,067	12·39	47	*Nil*	*Nil*	109,422	492,403	4·50	133,339	783,414	5·88
Great Indian Peninsula	1939	1,184	23,783	20·09	13,471	237,903	17·71	357	21,809	61·09	62,479	484,608	7·75	77,491	767,703	9·91
	1940	1,207	23,816	19·73	13,607	225,490	16·57	357	9,979	27·95	63,437	592,908	9·35	78,608	852,193	10·84
Jodhpur	1939	38	686	18·05	1,626	9,400	5·78	4,617	15,167	3·28	2,218	7,902	3·56	8,499	33,155	3·90
	1940	38	137	3·60	1,676	8,926	5·32	4,815	18,110	3·76	2,137	7,897	3·69	8,666	35,070	4·05
Madras and Southern Mahratta ..	1939	291	1,563	5·37	9,791	137,241	14·02	*	*	*	37,788	268,318	7·07	47,870	407,122	8·50
	1940	265	2,082	7·86	9,552	129,875	13·64	101	6,075	60·14	36,712	306,236	8·34	46,600	444,268	9·53

TABLE 21.—*Railway Department (Railway Board)*—contd.

Statement of Medical Statistics of Subordinate Staff on Class 1 Indian Railway and Colliery Staff under Chief Mining Engineer—contd.

Railways.	Year.	Subordinates drawing Rs. 250 p. m. or over on scales of pay rising to Rs. 250 p.m. or over.			On scales of pay rising to Rs. 30 p. m. or over but below Rs. 250 p. m.			On scales of pay below Rs. 30 p. m.			Daily rated labour and inferior staff			Total		
		Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in the year)	Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in the year)	Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in the year)	Strength of Staff	Number of Sick days leave granted	Sickness incidence per the workers (days in the year)	Strength of Staff	Number of sick days leave granted	Sickness incidence per the worker (days in the year)
Mysore State	1939	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	1940	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Nizam's State	1939	89	160	1·80	4,332	37,803	8·73	10,338	72,415	7·00	*Nil*	*Nil*	*Nil*	14,759	110,378	7·47
	1940	95	141	1·47	4,507	41,285	9·16	10,227	77,704	7·58	*Nil*	*Nil*	*Nil*	14,829	119,130	8·03
North Western	1939	1,322	10,547	7·97	17,734	137,444	7·75	2,530	16,528	6·53	80,001	246,295	3·08	101,587	410,918	4·08
	1940	1,316	11,046	8·39	17,745	158,853	8·95	2,421	21,183	8·75	82,051	242,152	2·95	103,533	432,934	4·14
Rohilkund and Kumaon	1939	22	148	6·73	933	7,971	8·54	13	28	2·15	5,019	14,272	2·84	5,987	22,419	3·74
	1940	23	132	5·74	1,004	10,225	10·18	10	48	4·80	5,088	18,948	3·72	6,125	29,353	4·78
South Indian	1939	256	1,424	5·56	9,820	126,627	12·89	*	*	*	26,596	114,727	4·31	36,672	242,778	6·62
	1940	254	1,765	6·95	9,986	114,410	11·45	*	*	*	27,357	141,907	5·19	37,597	258,082	6·86
Chief Mining Engineer	1939	56	803	14·34	754	4,534	6·01	245	1,293	5·28	5,733	23,693	4·12	6,714	30,190	4·49
	1940	56	722	12·88	733	6,643	9·06	231	1,116	4·83	5,352	35,551	6·83	6,338	44,989	7·09
All Railways	1939	7,549	71,149	9·42	*125,583	1,474,796	11·74	21,848	175,281	8·02	506,278	2,531,204	4·99	661,184	4,252,277	6·43
	1940	7,540	69,942	9·27	126,544	1,483,738	11·72	21,744	171,416	7·88	503,822	2,786,375	5·47	664,616	4,511,218	6·78

*Included under the group Rs. 30 to 250 p. m.

For information regarding leave rules, (etc.,) on the Railways, see the next page. As the sickness incidence is calculated from the number of days of sick leave granted, the rate of incidence is "net".

The system of Sickness Insurance is not in force on any State-owned Railway in India. The Railways have their own medical organizations and all Railway employees are normally entitled to gratuitous medical attendance at Railway hospitals and dispensaries for themselves and their families and for themselves, when necessary, at their residence. Low paid employees drawing less than Rs. 50 (the limit on certain railways is Rs. 75) are also entitled to free medical attendance for their families at their homes. Free diet is supplied to employees whose pay is Rs. 30 or less who are admitted as indoor patients.

2. Sickness due to injury while on duty is covered by Workmen's Compensation Act. Otherwise leave to daily rated and inferior staff is provided for on the following scale :—

Length of service.	*Leave earned.*
Less than 3 years.	*Nil.*
3 years and over but less than 10 years.	10 days in a calendar year.
10 years and over but less than 20 years.	15 days in a calendar year.
20 years and over.	20 days in a calendar year.

The leave as detailed above can be accumulated up to 30 days. Daily rated workshop staff after completion of one year's service are given certain holidays with pay, the number of holidays ranging from about 14 to 20 in a year.

In addition to the above, leave on half average pay on medical certificate is granted to daily rated staff with over 10 years' service on the following scale :—

10 years and over but less than 20 years ..	Not exceeding 15 days in a calendar year and 60 days in all.
20 years and over	Not exceeding 30 days in a calendar year and 120 days in all including such leave taken before the completion of 20 years service.

3. In addition to the above privileges, advances from the Provident Fund are allowed to subscribers to meet especially heavy expenditure incurred on themselves or their families during illness.

4. (a) Railway servants are eligible for gratuity (termed special contribution to Provident Fund in the case of subscribers to the Fund) equivalent to half a month's pay for each completed year of qualifying service subject to a maximum of 15 months pay on retirement or resignation on adequate grounds after completion of 15 years' service, and due to physical or mental incapacity even after less than 15 years' service. In cases of less than 15 years' qualifying service, the gratuity may, in special cases, be raised to one month's pay for each completed year of qualifying service subject to a maximum of 6 months pay in all.

(b) If a Railway servant dies in service, his widow and/or dependent children are granted the gratuity to which he would have been eligible, if he had been permanently incapacitated from further service by physical or mental infirmity.

(c) Irrespective of the restrictions applicable to the grant of ordinary gratuity, when a Railway servant dies in service, whether permanent or temporary, and his services have been of the approved standard, his widow, children, parents, brothers or sisters who were dependent on him and have been left in strained circumstances are eligible for compassionate gratuity at the rate of half a month's pay for every completed year of service, permanent or temporary put in by the deceased, subject to a maximum of six months' pay, which may, in deserving cases, be increased to 12 months pay.

TABLE 22.—*Sickness Incidence (General Table).*

Factory.	Kind of Industry.	Male.					Female.					Total				
		Number of Workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness (in days).	Number of Workers.	Number of case of sickness.	Total number of days lost in sickness	Average incidence of sickness (days per pear).	Average duration of illness (in days).	Number of Workers.	Number of cases of illness.	Total number of days lost in sickness.	Average incidence of sickness (days per year)	Average duration of illness (in days).
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Assam Oil Co., Digboi (*a*)—1942.	Minerals & Metals ..	8,009	13,102	80,873½	10·09	6·2	31	29	259	8·36	8·9	8,040	13,131	81,132½	10·09	6·2
Buckingham & Carnatic Mills, Madras (*a*)—1941.	Textile ..	..	..	..	..	..	..	..	..	..	..	11,282	..	68,137	6·38	..
Buckingham & Carnatic Mills, Madras (*a*)—1942.	Do. ..	..	..	..	..	..	..	..	..	..	..	11,979	..	70,183	5·80	..
Madura Mills Co., Madura—Madura Mills (*a*)—1942.	Do. ..	..	..	..	..	..	..	..	..	..	..	3,141,334*	..	132,130	13·1	..
Madura Mills Co., Madura—Pandyan Mills (*a*)—1942.	Do. ..	..	..	..	..	..	..	..	..	..	..	495,196*	..	16,946	12·1	..
Madura Mills Co., Madu Tuticorin Mills (*a*)—1942.	Do. ..	..	..	..	..	..	..	..	..	..	..	1,384,785*	..	63,309	14·0	..
Madura Mills Co., Madara—Ambasamudram Mills (*a*)—1942.	Do. ..	..	..	..	..	..	..	..	..	..	..	2,019,032*	..	95,887	14·6	..
Indian Copper Corporation, Ghatsila—Masabani Mines (*a*)—1940.	Minerals & Metals ..	3,276	12,018	36,353	11·09	3·0	320	173	2,997	9·37	17·3	3,596	12,191	39,350	10·94	3·2
Indian Copper Corporation, Ghatsila—Moulhander Works (*a*)—1940.	Do. ..	1,429	6,820	9,767	6·83	1·4	159	113	863	5·43	7·6	1,588	6,933	10,630	6·69	1·5
Lyallpur Cotton Mills (*a*)—1941-42.	Textile ..	..	..	..	..	..	..	..	..	..	..	4,044	729	6,587	1·63	9·0
Delhi Cloth Mills (*a*)—1941.	Do. ..	..	..	..	..	..	..	..	..	..	..	4,043	1,837	8,550	2·06	4·6

(1)	(2)		(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	12)	(12)	(14)	(15)	(16)	(17)
Delhi Cloth Mill (*a*) 1942..		..	..	..	..	..	..	..	..	..	..	..	10,520	3,572	51,859	4·93	14·5
Andhra Paper Mills Co., Rajahmundry (*a*).	Misc.	..	591	190	2,179	3·68	11·5	125	22	316	2·54	14·4	716	212	2,395	3·34	11·5
Swastik Oil Mills Ltd., Vadala.	Do.	..	890	209	892	1·0	4·3	60	60	65	1·04	1·0	950	269	957	1·01	3·5
Rajalakshmi Mills Ltd., Uppilipalaya—1942.	Textile	..	928	928	8,554	9·22	9·2	360	360	3,402	9·45	9·5	1,288	1,288	11,956	9·28	9·3
New Satgram Colliery, Burdwan Dt.—1942.	Minerals & Metals	..	85	112	324	3·81	2·0	16	21	42	2·62	2·0	101	183	366	3·62	2·0
East India Tramways Co., Ltd., Karachi (*a*)	Engineering	..	400	..	1,080	2·70	..	..	..	..	..	..	400	..	1,080	2·70	..
Addisson & Co. Ltd., Madras.	,,	..	493	106	343	0·69	3·2	..	..	..	..	..	493	106	343	0·69	2·2
Binny & Co., Beach Engineering Works, Madras.	,,	..	813	271	1,351	1·65	5·0	..	..	..	..	..	813	271	1,351	1·65	5·0
Jyoti Ltd., Baroda	,,		231	93	857	3·71	9·2	..	..	..	..	..	231	93	857	3·71	9·2
Motilal Agarwala Mills Ltd., Gwalior—1941.	Textile	..	3,419	3,503	28,970	8·47	8·3	..	..	..	..	..	3,419	3,503	28,970	8·47	8·3
Motilal Agarwala Mills Ltd., Gwalior—1942.	,,	..	3,538	4,105	40,387	11·41	9·8	..	..	..	..	..	3,538	4,105	40,387	11·41	9·8
Bangalore Woollen Cotton and Silk Mills, Bangalore (*a*)	,,	..	6,186	2,384	16,495	2·67	6·9	461	136	980	2·12	7·2	6,647	2,520	17,475	2·63	6·9
Western India Match Co., Madras	Miscellaneous	..	870	336	4,499	5·17	13·4	32	15	189	5·91	12·3	902	351	4,688	5·19	13·3
Associated Cement Cos., Kistna Cement Works.	,,	..	332	240	943	2·84	3·9	10	47	243	24·3	5·2	342	287	1,186	3·47	4·1
Cambodia Mills, Coimbatore.	Textile	..	1,657	6,156	11,446	6·91	1·8	583	2,602	4,584	7·68	1·7	2,240	8,758	16,030	7·15	1·8
Mettur Industries Ltd., Madras.	Miscellaneous	..	2,026	730	4,600	2·27	6·2	51	8	47	0·92	6·0	2,077	738	4,647	2·24	6·3
Sirpur Paper Mills, Hyderabad (Dn.)	,,	..	1,271	183	2,573	2·02	14·0	..	..	..	..	..	1,271	183	2,573	2·02	14·0
Salem-Erode Electric Distribution Co., Madras.	Engineering	..	128	69	1,029	8·04	14·9	..	..	..	..	..	128	69	1,029	8·04	14·9
Mangalore Electric Supply Co., Mangalore.	,,	..	78	61	927	11·88	15·2	..	..	..	..	..	78	61	927	11·88	15·2
Associated Cement Co., Coimbatore Cement Works, Coimbatore.	Miscellaneous	..	574	567	2,409	4·19	4·2	89	46	265	2·98	5·8	663	613	2,674	4·03	4·4
Lakshmiratan Cotton Mills, Cawnpore.	Textile	..	3,700	36,036	7,560	2·04	..	48	308	84	1·75	..	3,748	36,344	7,644	2·04	..
Tinplate Co. of India Ltd., Golmuri (*a*).	Minerals & Metals	..	2,414	2,063	31,092	9·11	15·1	137	111	1,89	13·80	17·0	3,551	2,174	32,981	9·29	15·1
Madras Electric Tramways, Ltd., Madras	Engineering	..	340	89	959	2·89	10·8	5	5	*Nil*	*Nil*	..	345	94	2·78	2·78	10·2
Rifle Factory, Ishapur, 1940-41	,,	..	..	..	..	..	..	..	..	..	..	..	5,621	..	30,805	5·48	..

TABLE 22.—*Sickness Incidence (General Table)*—contd.

Industry.	Kind of Industry.	Male.					Female.					Total.				
		Number of workers.	Number of case of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year.)	Average duration of illness (in days).	Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness (in days).	Number of workers.	Number of cases of illness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness (in days)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Rifle Factory Ishapur, 1941-42	Engneering ..	..	..	..	..	..	..	..	..	..	..	5,621	..	30,805	5·48	..
,, 1942-43	,, ..	..	..	..	..	..	..	..	..	..	..	8,189	..	62,220	7·60	..
Cordite Factory, Aruvankadu, 1940-41.	Miscellaneous ..	..	..	..	..	..	..	..	..	..	..	2,061	..	7,015	3·40	..
Cordite Factory, Aruvankadu, 1941-42.	,, ..	..	..	..	..	..	..	..	..	..	..	2,946	..	7,930	2·69	..
Cordite factory, Aruvankadu, 1942-43.	,, ..	..	..	..	..	..	..	..	..	..	..	3,802	..	16,470	4·33	..
H. & S. Factory, Cawnpore, 1941-42.	,, ..	..	..	..	..	..	..	..	..	..	..	5,907	..	78,995	13·37	..
Mathematical Instruments Office, Calcutta, 1942-43	Engineering ..	..	..	..	..	..	..	..	..	..	..	1,385	..	5,705	4·18	..
Gun & Carriage Factory, Jubbulpore, 1940-41.	,, ..	..	..	..	..	..	..	..	..	..	..	4,673	..	69,845	14·93	..
Gun & Carriage Factory, Jubbulpore, 1941-42.	,, ..	..	..	..	..	..	..	..	..	..	..	6,019	..	88,755	14·74	..
Gun & Carriage Factory, Jubbulpore, 1942-43	,, ..	..	..	..	..	..	..	..	..	..	..	8,624	..	89,975	10·43	..
Empress Mills, Nagpur (*a*)	Textile ..	..	..	..	..	..	..	..	..	..	..	17,00	..	91,416	5·38	..
Tata Hydro-electric Generating Stations:																
Khopoli ..	Engineering ..	..	..	..	..	..	..	..	..	..	..	131	..	365	2·79	..
Bhivpuri ..	.. ,, ..	..	..	..	..	..	..	..	..	..	..	152	..	844	5·53	..
Bhira ..	.. ,, ..	..	..	..	..	..	..	..	..	..	..	248	..	303	1·22	..
Tata Iron and Steel Co., Jamshedpur—(*a*)																
1941-42	.. ,, ..	..	..	..	..	..	..	..	..	..	..	..	..	190,641	6·52	12·6
1942-43	.. ,, ..	..	..	..	..	..	..	..	..	..	..	..	..	220,933	7·04	12.3

(1)	(2)		(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
The Tata Iron and Steel Minerals Co., (Colliery Department) :—Jamadoba	Minerals and Metals.	..	2,478	5,801	12,602	5·09	2·2	216	1,139	471	2·18	0·4	2,694	6,940	13,073	4·85	1·9
Digwadih ..	,,	..	2,362	3,047	18,282	7·74	6·0	17	557	445	2·60	0·8	2,379	3,604	18,727	7·87	5·2
Malkera-Choitodih	,,	..	2,092	1,552	11,966	5·73	7·7	248	80	593	2·39	7·4	2,340	1,632	12,545	5·36	7·7
Sigua ..	,,	..	2,002	1,227	9,673	4·83	7·6	981	112	946	0·96	8·4	2,983	1,389	10,618	3·56	7·6
Bombay Electric Supply and Tramways Co., Ltd., Bombay.(a).	Engineering	..	..	..	..	..	..	..	..	..	..	..	6,616	5,724	45,792	6·92	8·0
The Bata Shoe Co., Ltd., Batanagar (a).	Miscellaneous	..	..	..	..	..	..	..	..	..	..	..	6,815	33,813	55,200	8·10	1·6

*Number of Man-days on roll.

(a) Where cash benefit or sick leave with pay was given.

TABLE 23.—*Sickness Incidence in the Textile Industry.*

Name of concern.	Male.					Female					Total				
	Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Average duration of illness (in days).	Number of workers.	Number of cases of sickness.	Total number of days lost in sickness.	Average incidence of sickness (days per year)	Average duration of illness (in days)	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness (in days)
Buckingham & Carnatic Mills, Madras (a) 1941	..	..	..	..	..	..	..	..	..	..	11,282	..	69,137	6·38	..
,, ,, ,, 1942	..	..	..	..	..	..	..	..	..	..	11,979	..	70,183	5·84	..
Madura Mills, Co.—Madura Mills (a) 1942	..	..	..	..	..	..	..	..	..	..	3,141,334*	..	132,130	13·1	..
,, Pandyan Mills (a) 1942	..	..	..	..	..	..	..	..	..	..	495,196*	..	16,946	12·1	..
,, Tuticorin Mills (a) 1942	..	..	..	..	..	..	..	..	..	..	1,384,785*	..	63,309	14·0	..
,, Ambassamudram Mills (a) 1942.	*	..	..	..	..	..	..	..	..	..	1,019,032*	..	95,887	14·6	..
Lyallpur Cotton Mills, Lyallpur (a) 1941-42	..	..	..	..	..	..	..	..	..	..	4,044	729	6,587	1·68	9·0
Delhi Cloth Mills, Delhi (a) 1941	..	..	..	..	..	..	..	..	..	..	4,143	1,837	8,550	2·06	4·6
,, ,, ,, 1942	..	..	..	..	..	..	..	..	..	..	10,520	3,572	11,859	4·93	14.5
Rajalakshmi Mills, Uppilipalayam, 1942	..	928	928	8,554	9·22	992	360	360	3,402	9·45	9·5	1,288	1,288	11,956	9·28	9·3
Motilal Agarwala Mills, Ltd., Gwalior, 1941	..	3,419	3,503	28,970	8·47	8·3	..	..	..	..	..	3,419	3,503	28,970	8·47	8·3
,, ,, ,, ,, 1942	..	3,538	4,105	40,387	11·41	9·8	..	..	..	..	..	3,538	4,105	40,387	11·41	9·8
Bangalore Woollen, Cotton & Silk Mills, Bangalore (a).		6,186	2,384	16,496	2·67	6·9	461	136	980	2·12	7·2	6,647	2,520	17,475	2·63	6·9
Cambodia Mills, Coimbatore		1,657	6,156	11,446	6·91	1·8	583	2,602	4,584	7·86	1·7	2,240	8,758	16,030	7·15	1·8
Lakshmiratan Cotton Mills, Co., Cawnpore ..		3,700	36,036	7,560	2·04	..	48	308	84	1·75	..	3,748	36,244	7,644	2·04	..
Empress Mills, Nagpur		..	..	..	..	..	..	..	..	..	..	17,000	..	91,416	5·38	..
Total ..		19,428	..	113,412	5·84	..	1,452	..	9,050	6·23	..	1,02,415	..	727,466	7·10	..

* Number of Mandays on roll. In adding up the total these have been reduced to number of workers by dividing the days lost by the incidence of sickness.
(a) Where cash benefit or sick leave with pay was given.

TABLE 24.– *Sickness Incidence in Engineering Industry.*

Name of concern.	Male.					Female					Total				
	Number of workers	Number of cases of sickness	Total numbers of days lost in sickness	Aerage incidence of sickness. (days per year)	Average duration of illness (in days)	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Averg incidence of sickness, (days per year)	Average duration of illness (in days)	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness (in days)
East India Tramways Co., Karachi (*a*) ..	400	..	1,080	2·70	..	..	..	..	..	..	400	..	1,080	2·70	..
Addison & Co., Madras	493	106	341	0169	3·2	..	..	..	..	..	493	106	343	0·69	3·2
Binny & Co. Beach Engineering Works, Madras	813	271	1,351	1·65	5·0	..	..	..	..	..	813	271	1,351	1·65	5·0
Jyoti Ltd. Baroda	231	93	857	3·71	9·2	..	..	..	..	..	231	93	957	3·71	9·2
Salem-Erode Electric Distribution Co., Madras ..	128	69	1,029	8·04	14·9	..	..	..	..	..	128	69	1,029	8·04	14·9
Mangalore Electric Supply Co., Mangalore ..	78	67	927	11·88	15·2	..	..	..	..	..	78	67	927	11·88	15·2
Madras Electric Tramways Ltd., Madras ..	340	89	959	2·82	10·8	5	5	*Nil*	..	..	345	94	959	2·78	10·2
Rifle Factory, Ishapur, 1940-41	..	..	..	..	..	..	..	..	..	..	5,021	...	30,805	5·48	..
Rifle Factory, Ishapur, 1941-42	..	..	..	..	..	..	..	..	..	..	7,225	..	52,765	7·30	..
Rifle Factory, Ishapur, 1942-43	..	..	..	..	..	..	..	..	..	..	8,199	..	61,220	6·60	..
Mathematical Instruments Office, Calcutta, 1942-43	..	..	..	..	..	..	..	..	..	..	1,385	..	5,795	4·18	..
Gun & Carriage Factory, Jubbulpore, 1940-41 ..	..	..	..	..	..	..	..	..	..	..	4,673	..	69,845	14·93	..
Gun & Carriage, Factory, Jubbulpore, 1941-42 ..	..	..	..	..	..	..	..	..	..	..	6,019	..	88,755	14·74	..
Gun & Carriage Factory, Jubbulpore, 1942-43 ..	..	..	..	..	..	..	..	..	..	..	8,624	..	89,975	10·43	..
The Tata Hydro-electric Generating Stations :—															
Khopoli	..	..	..	..	..	..	..	..	..	..	131	..	365	2·79	..
Bhivpuri	..	..	..	..	..	..	..	..	..	..	152	..	844·5	5·56	..
Bhira	..	..	..	..	..	..	..	..	..	..	248	..	303	1·22	..
The Tata Iron and Steel (*a*) Co., Jamshedpur—															
1941-42	..	..	..	..	..	..	..	..	..	..	..	..	190,641	6·52	12·6
1942-43	..	..	..	..	..	..	..	..	..	..	*	..	220,93[illegible]	7·01	12·3
The Bombay Electric (*a*) Supply and Tramways Co., Ltd., Bombay.	..	..	..	..	..	..	..	..	..	..	6,616	5,724	45,792	6·92	8·0
Total ..	..	..	..	..	..	..	..	..	..	..	82.763*	..	674,944	8·15	..

(*a*) Where cash benefit or sick leave with pay was given.

* The number of workers has been commuted by dividing the number of man-days lost by the rate of incidence and the result added to arrive at the total.

TABLE 25. *Sickness Incidence in Minerals and Metals Industry.*

Province or State	Male.					Female					Total				
	Number of workers	Number of cases of sickness	Total numbers of days lost in sickness	Average incidence of sickness. (days per year)	Average duration of illness (in days)	Number of workers	Number of cases	Total number of days lost in sickness	Average incidence of sickness, (days per year)	Average duration of illness (in days)	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness (in days)
Assam Oil Co., Digboi (*a*) 1942	8,009	13,102	80,873½	10·09	6·2	31	29	259	8·36	8,040	13,131	..	81,132	10·09	6·2
Indian Copper Corporation-Mosaboni Mines (*a*) 1940	3,276	12,018	36,353	11·09	3·0	320	173	2,997	9·37	17·3	3,596	12,191	39,350	10·94	3·2
Indian Copper Corporation Moubhander Works (*a*) 1940.	1,429	86,820	9,767	6·83	1·4	159	113	863	5·43	766	1,588	6,933	10,630	6·69	1·5
New Satgram Colliery, Burdwan Dt. 1940	85	162	324	3·81	2·0	16	21	42	2·62	2·0	101	·83	366	3·62	2·0
Tinplate Co. of India, Golmuri	3,414	2,063	31,092	9·11	15·1	137	111	1,889	13·80	17·0	3,551	2,174	32,981	9·29	5·1
The Tata Iron and Steel Co., (Colliery Department) :—															
Jamadoba	2,478	5,801	12,602	5·09	2·2	216	13,19	471	2·18	0·4	2,694	6,940	13,073	4·85	1·9
Digwadih	2,362	3,047	18,282	7·74	6·0	17	557	445	2·60	0·8	2,379	3,604	18,727	7·87	5·2
Malkera-Choitodih	2,092	1 552	11,966	5·73	7·7	248	80	593	2·39	7·4	2,340	1,632	12,545	5·36	7·7
Sigua	2,002	21,77	9,673	4·83	7·6	981	112	946	0·96	8·4	2,983	1,389	10,619	3·56	7·6
Total ..	25,147	45,842	210,933	8·39	4·6	2,125	2,335	8,505	4·00	3·6	27,272	48,177	219,424	8·05	4.5

(*a*) Where cash benefit or sick leave with pay was given.

TABLE 26.—*Sickness Incidence according to Provinces and States.*

Province or State	Male.					Female					Total				
	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness (in days)	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness (in days)	Number of workers	Number of cases of sickness	Total number of days lost in sickness	Average incidence of sickness (days per year)	Average duration of illness (in days)
Assam	8009	13,102	80,874	10·09	6·2	31	29	259	8·36	8·9	8,040	13,131	81,133	10·09	6·2
Bengal	85	112	324	3·81	2·0	16	21	42	2·62	2·0	1,486	..	6,161	4·15	..
Bihar	8,119	20,301	77.212	9·51	3·7	616	397	5,749	9·33	14·5	57,859	..	415,570	7·18	..
Orissa	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Madras	8,830	9,743	39,239	4·44	4·0	1,255	3,105	9,046	7·21	29	46,667	..	456,141	9·77	..
Central Provinces & Berar	..	..	..	..	..	..	..	..	..	..	17,000	..	91,416	5·38	..
Bombay	890	209	692	1·0	4·3	..	..	..	..	..	7,506	..	46,684	6·22	..
Sind	400	..	1,080	2·7	..	..	..	..	..	..	400	..	1,080	2·70	..
Punjab	..	..	..	..	..	..	..	..	..	..	4,044	729	6,587	1·63	9·0
North-West Frontier Province	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
United Provinces	3,700	..	7,560	2·04	..	48	..	84	1·75	..	58,825	..	512,419	8171	..
Delhi	..	..	..	..	..	..	..	..	..	..	10,520	3,572	51,859	4·93	14·5
Ajmer-Merwara	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Baroda	231	93	857	3·71	9·2	..	..	..	..	..	231	93	857	3·71	9·2
Hyderabad	1,271	183	2,573	2·02	14·0	..	..	..	..	..	1,271	183	2,573	2·02	14·0
Gwalior	3,538	4,105	40,387	11·41	9·8	..	..	..	..	..	3,538	4,105	40,387	11·41	9·8
Mysore	6,186	2,284	16,495	2·67	6·9	461	136	980	2·12	7·2	6,647	2,520	17,475	2·63	6·9

N.B.—The figures given are not for the Province as a whole. Figures for those industries only that have supplied useful statistics have been put under various Provinces.

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TABLES 27 AND 28.—*Differential Rates of Sickness Incidence for Urban and Mofussil Centres.*

Urban Centres.	Male			Female			Total		
Industry and centre.	Number of workers.	Total number of days lost in sickness.	Average incidence of sickness (days per year).	Number of workers.	Total number of days lost in sickness.	Average incidence of sickness.	Number of workers.	Total number of days lost in sickness.	Average incidence of sickness.
Buckingham & Carnatic Mills, Madras.	..	..	..	..	..	..	11,979**	70,183	5·80
Madura Mills, Madura ..	..	..	..	..	..	..	3,141,334	132,130	13·1
Pandyan Mills, Madura ..	..	..	..	..	..	..	495,196**	16,946	12·1*
Lyallpur Cotton Mills, Lyallpur.	..	..	..	..	..	..	4,044	6,587	1·63*
Delhi Cloth Mills, Delhi ..	..	..	..	..	..	..	10,520	51,589	4·93
Swastik oil mills, Vadala, Bombay.	890	892	1·0	60	65	65	950	957	1·01
East India Tramways Co., Karachi.	400	1,080	2·70	..	..	..	400	1,080	2·70*
Addison & Co., Madras Binny & Co., Beach.	493	345	0·69	..	..	..	493	343	0·69
Engineering Works, Madras	813	1,351	1·65	..	..	..	813	1,351	1·65
Jyoti Ltd., Baroda ..	231	857	3·71	..	..	..	231	857	3·7
Motilal Agarwal Mills, Gwalior.	3,538	40,387	11·41	..	..	..	3,538	40,337	11·41
Bangalore Woollen, Cotton and Silk Mills, Bangalore.	6,186	16,495	2·67	461	980	2·12	6,647	17,475	2·63
Western India Match Co., Madras.	870	4,499	5·17	32	189	5·91	902	4,688	5·19
Cambodia Mills, Coimbatore	1,657	11,446	6·91	583	4,584	7·86	2,240	16,030	7115
Coimbatore Cement Works, Coimbatore.	574	2,409	4·19	89	265	2·98	663	2,674	4·03
Lakshmiratan Cotton Mills, Cawnpore.	3,700	7,560	2·04	48	84	1·75	3,748	7,644	2·04
Madras Electric Tramways Ltd., Madras.	340	959	2·82	5	..	..	345	959	2·78
Mathematical Instrument Office, Calcutta.	..	..	..	..	..	..	1,385	5,795	4·18
Gun and Carriage Factory, Jubbulpore.	..	..	..	..	..	..	8,624	89,975	10·43
Express Mills, Nagpur ..	..	..	..	..	..	..	17,000	91,416	5·38*
Tata Iron and Steel Co., Jamshedpur.	..	..	..	..	..	..	..	220,933	7·04*
Bombay Electric Supply and Tramways Co., Ltd., Bombay.	..	..	..	..	..	..	6,615	45,792	6·92*
					Total	..	92,624	826,791	8·92

*Where cash benefit or sick leave with pay was given.

**Number of Man-days on roll. In adding up the total these have been reduced to number of workers by dividing the days lost by the incidence of sickness.

TABLES 27 AND 28.—*Differential Rates of Sickness Incidence for Urban and Mofussil Centres.*

Mofussil Centres.	Male			Female			Total		
Industry and centre.	Number of workers.	*Total number of days lost in sickness.	Average incidence of sickness (days per year).	Number of workers.	Total number of days lost in sickness.	Average incidence of sickness.	Number of workers.	Total number of days lost in sickness.	Average incidence of sickness.
Assam Oil Co., Digboi ..	8,009	80,874	10,09	31	259	8·36	8,040	81,133	10·09*
Tuticorin Mills, Tuticorin	..	..	..	..	..	..	1,384,785**	63,309	14·00*
Ambasamudram Mills, Ambasamudram.	..	..	..	..	..	..	2,019,032**	95,887	14·60*
Indian Copper Corporation, Ghatsila.	1,429	9,767	6·83	159	863	5·43	1,588	10,630	6·69
Moubhander Works Masaboni Mines.	3,276	12,018	11·09	320	2,997	9·37	3,596	39,350	10·94*
Andhra Paper Mills, Rajahmundry.	591	2,179	3·68	125	316	2·54	716	2,395	3·34*
Rajalakshmi Mills, Uppilipalayam.	928	8,554	9·22	360	3,402	9·45	1,288	11,956	9·28
New Satgram Colliery, Burdwan Dt.	85	324	3·81	16	42	2·62	101	366	3·62
Associated Cement Co., Kistna.	332	943	2·84	10	243	24·30	342	1,186	3·47
Sirpur Paper Mills, Hyderabad (Dn.).	1,271	2,573	2·02	..	..	..	1,271	2,573	2·0
Salem Erode Electric Distribution Co., Salem.	128	1,029	8·04	..	..	..	128	1,029	8·0
Mangalore Electric Supply Co., Mangalore.	78	927	11·88	..	..	..	78	927	11·88
Tinplate Co., of India, Golmuri.	3,414	31,092	9·11	137	1,889	13·80	3,551	32,981	9·29*
Rifle Factory, Ishapur ..	..	..	..	..	..	..	8,199	62,220	7·60
Cordite Factory, Aruvankadu.	..	..	..	..	..	..	3,802	16,470	4·33
Tata Hydro-electric Generating Stations :—									
Khopoli	..	..	..	..	..	..	131	365	2·79
Bhivpuri	..	..	..	..	..	..	152	845	5·55
Bhira	..	..	..	..	..	..	248	303	1·22
Tata Iron and Steel Co., Colliery Dept :—									
Hamadoba	2,478	12,602	5·09	216	471	2·18	2,694	13,073	4·85
Digwadih	2,362	18,282	7·74	17	445	27·00	2,379	18,727	7·87
Malkera-Choitodih ..	2,092	11,066	5·73	248	593	2·39	2,340	12,545	5·36
Sigua	2,002	9,673	4·83	981	946	0·96	2,983	10,619	3·56
Bata Shoe Co., Batanagar	..	..	..	..	..	..	6,815	55,200	8·10
Perry and Co., Nellikuppam	..	..	..	..	..	..	1,427	23,259	16·30
Ranipet Factory ..	..	..	..	..	..	..	1,459	7,718	5·29
Samalkot Factory ..	..	..	..	..	..	..	509	1,899	3·73
Thuckalay Factory ..	..	..	..	..	..	..	54	1,067	19·76
					Total ..		64,950	563,032	8·74

*Where cash benefit or sick leave with pay was given.

**Number of Man-days on roll. In adding up the total these have been reduced to number of workers by dividing the days lost by the incidence of sickness.

TABLE 29.—*Average daily number of workers employed in perennial factories in the different industries.*

Industry.	Madras.	Bombay.	Sind.	Bengal.	U. P.	Punjab.	Bihar.	Orissa.	C. P. & Berar.	Assam.	N.W. F.P.	Baluchistan.	Ajmer-Merwara.	Delhi.	Bangalore. Coorg.	Total.
All Textiles—																
1939	72,290	308,753	100	317,910	53,155	16,234	6,815	..	22,230	..	..	..	5,279	11,311	..	817,077
1940	79,530	306,564	353	322,791	54,884	15,779	7,446	..	23,909	14	..	..	5,296	12,596	..	829,162
1941	89,200	387,448	426	331,521	67,243	20,148	9,963	..	27,154	12	..	..	5,625	14,580	..	953,320
1942	94,571	387,904	211	332,285	69,704	20,989	8,757	..	30,196	11	..	..	7,124	13,650	..	965,402
All Engineering—																
1939	17,637	30,929	2,228	65,247	7,708	3,116	10,288	450	1,695	1,780	94	265	6,360	555	76	148,428
1940	19,064	32,474	2,714	71,650	8,683	3,657	8,670	429	1,879	1,811	107	293	6,598	576	70	158,665
1941	22,650	43,954	3,993	92,517	10,427	7,785	10,181	492	1,920	1,791	139	312	7,207	605	82	204,056
1942	27,390	50,833	4,126	104,311	10,855	11,654	11,382	500	2,042	2,068	97	218	..	1,510	222	224,430
All Minerals and Metals—																
1939	2,011	1,280	64	17,633	1,005	3,465	27,283	..	..	2,178	..	..	..	204	..	55,123
1940	1,706	1,291	85	17,864	1,458	4,387	33,590	..	10	1,585	..	..	..	381	..	62,357
1941	2,389	2,191	..	21,178	4,492	7,367	36,052	..	..	1,879	..	..	..	301	..	76,162
1942	2,191	2,724	..	23,199	5,426	9,417	36,343	..	..	2,142	..	..	..	627	..	82,069
Total—																
1939	94,938	340,962	2,392	400,790	61,868	22,815	44,386	450	23,925	3,958	94	265	11,639	12,070	76	1,020,628
1940	100,300	340,309	3,152	412,305	65,025	23,823	49,70	429	25,788	3,140	107	293	11,894	13,553	70	1,050,184
1941	114,239	433,593	4,419	445,216	82,162	35,300	56,196	473	29,074	3,682	139	312	12,832	15,786	82	1,233,438
1942	124,152	441,461	4,337	459,795	85,985	42,060	56,482	500	32,238	4,221	97	218	7,124	15,787	222	1,271,901

TABLE 30.—*Average daily number of persons employed in large Industrial Establishments in Indian States.*

State.	Year.	All textiles.	All engineering.	All minerals and metals.	Other industries.	Total.
Mysore	1940	22,159	3,544	28,542	29,676	83,921
	1941	23,932	8,017	28,086	20,420	80,455
Hyderabad	1938-39	9,501	..	882	..	10,383
	1939-40	10,532	..	817	..	11,349
	1940-41	12,158	..	881	..	13,039
	1941-42	13,346	..	1,701	..	15,047
Baroda	1939-40	31,047	492	..	5,604	37,13
	1940-41	33,609	568	..	6,927	41,104
	1941-42	33,757	690	..	6,632	31,388
	1942-43	34,515	758	..	7,815	43,088
Gwalior	1939	12,471	..	..	492	12,963
	1940	13,285	..	..	474	13,759
	1941	15,493	..	..	500	15,995
	1942	15,096	..	..	611	15,707
Indore	1938-39	21,281	..	..	..	21,281
	1939-40	19,865	..	..	..	19,865
	1940-41	22,075	..	..	..	22,075
	1941-42	25,393	..	..	..	25,393
Travancore	1939	817	1,080	4,203	..	6,100
	1940	828	1,861	5,379	..	7,393
	1941	1,179	1,372	2,933	..	5,484
	1942	1,433	1,530	1,788	..	4,751

TABLE 31.—*Sickness Experience—Types of Sickness*
(For All Industries)*

Disease.	Number of sick persons.				Number of days lost.			
	Male	Percentage to total	Females	Percentage to total	Man-days	Percentage to total	Woman-days	Percentage to total
Influenza	1,405	3·2	63	5·4	6,866	3·4	425	4·6
Malaria	2,090	4·8	165	14·1	7,750	3·8	700	7·6
Dysentery	1,523	3·4	55	4·8	3,445	1·7	361	3·9
Diarrhœa and other diseases of digestive system	3,868	8·8	61	5·2	10,588	5·3	311	3·4
Tuberculosis	96	0·2	..	..	1,098	0·5	..	..
Respiratory diseases other than Tuberculosis ..	3,476	7·8	62	11,829	11,829	5·8	399	4·3
Fever	3,859	8·8	135	11·6	47,927	23·9	1,912	20·6
Pyrexia	4,704	10·7	118	10·1	8,418	4·3	256	2·8
Venereal diseases ..	498	1·1	2·5	2·5	3,311	1·7	391	4·2
Skin diseases ..	1,230	2·8	7	016	1,690	0·8	10	0·1
Abscesses & boils ..	3,357	7·7	41	3·5	13,186	6·6	153	1·6
Eye, ear, nose troubles ..	2,378	5·4	41	3·5	4,259	2·1	247	2·7
Labour	..	..	24	2·1	..	..	221	2·4
Appendicitis	22	..	3	..	176	..	56	0·6
Accidents/Injuries ..	9,075	20·6	38	3·3	37,116	18·4	419	4·5
Miscellaneous ..	6,485	14·7	327	28·0	43,560	21·7	3,328	36·7
Total ..	44,066	100	1,169	100	201,218	100	9,259	100

* Figures may be taken as referring generally to the year 1942-43. They are the combined figures for such concerns as have supplied information. Only perhaps the percentages have some significance.

TABLE 32.—*Sickness Experience—Types of Sickness*

(Textile Industries).

Disease	Number of sick persons				Number of days lost			
	Male	Percentage to total	Female	Percentage to total	Man-days	Percentage to total	Woman-days	Percentage to total
Influenza	364	3·0	19	12·3	773	1·0	43	26·2
Malaria	568	4·7	10	6·5	372	0·5	6	3·6
Dysentery	93	0·7	2	1·3	203	0·2	3	1·8
Diarrhœa and other diseases of digestive system	1,644	13·5	22	14·3	6,885	8·7	4	2·4
Tuberculosis	5	..	..	..	3	..	..	..
Respiratory diseases other than Tuberculosis ..	1,437	11·8	24	15·5	7,667	9·7	27	16·4
Fever	..	..	..	..	18,508	23·4	..	..
Pyrexia	2,418	19·8	34	22·1	2,839	3·6	42	25·8
Venereal diseases ..	116	0·9	..	..	..	..	..	..
Skin diseases	355	2·9	..	..	18	..	..	..
Abscesses & boils ..	3,57	7·7	41	3·5	13,186	6·7	153	1·6
Eye, ear, nose troubles..	1,720	14·0	13	8·7	2,300	2·9	3	1·8
Labour	..	..	..	..	..	..	..	..
Appendicitis	..	..	..	..	..	..	..	..
Accidents/Injuries ..	114	0·8	..	..	8,947	11·3	..	..
Miscellaneous ..	1,293	10·6	16	10·3	19,622	24·8	23	14·0
Total ..	12.372	100	154	100	79.162	100	164	100

TABLE 33.—*Sickness Experience—Types of Sickness*

(Engineering Industries)

Disease	No. of Sick Persons				No. of days lost			
	Male	Percentage to total	Female	Percentage to total	Mandays	Percentage to total	Woman-days	Percentage to total
Influenza	151	1·3	5	1·0	753	1·7	21	0·6
Malaria	1,352	11·2	132	26·2	6,097	13·7	568	15·8
Dysentery	516	4·3	14	2·8	1,348	3·0	139	3·9
Diarrhœa and other diseases of digestive system ..	836	7·6	32	6·4	2,285	5·1	237	6·6
Tuberculosis	37	0·3	..	..	334	0·8	..	..
Respiratory diseases other than Tuberculosis ..	795	6·6	20	4·0	2,104	4·7	108	3·0
Fever	1,515	12·5	59	11·8	7,085	159	585	16·3
Pyrexia	415	3·4	18	3·6	2,356	5·3	106	2·9
Veneral diseases	206	1·7	14	2·8	2,206	4·9	196	5·5
Skin diseases	311	2·6	3	0·6	252	0·6	10	0·3
Abscesses and boils ..	247	2·0	2	014	745	1·7	49	1·3
Eye, ear, nose troubles ..	188	1·6	11	2·2	711	1·6	102	2·8
Labour	..	..	24	4·8	..	..	221	6·1
Appendicitis	21	0·2	3	0·6	167	0·3	56	1·6
Accidents/Injuries ..	3,635	30·2	29	5·8	7,207	16·2	264	7·4
Miscellaneous	1,817	15·1	135	27·0	10,922	24·5	927	25·9
Total ..	12,042	100	501	100	44,572	100	3,589	100

TABLE 34.—*Sickness Experience—Types of Sickness*

(Minerals and Metals Industries)

Disease	Number of sick persons				Number or days lost			
	Male	Percentage to total	Female	Percentage to total	Mandays	Percentage to total	Woman-days	Percentage to total
Influenza	580	3·8	29	8·5	4,641	6·9	317	6·5
Malaria	120	0·8	18	5·3	800	1·2	51	1·1
Dysentery	781	5·0	24	7·0	1,305	1·9	212	4·3
Diarrhœa and other diseases of digestive system.	1,185	7·7	9	2·7	1,419	2·1	62	1·3
Tuberculosis	52	0·3	..	..	756	1·1	..	..
Respiratory diseases other than Tuberculosis	1,121	7·2	14	4·1	1,730	2·6	211	4·3
Fever	2,344	15·1	76	22·6	22,333	33·2	1,327	27·1
Pyrexia	..	..	..	..	..	..	..	..
Veneral diseases	176	1·1	15	4·4	1,105	1·6	195	4·0
Skin diseases	464	3·0	4	1·1	420	0·6	..	..
Abscesses and boil ..	461	3·0	4	1·1	1,228	1·8	25	0·5
Eye, ear, nose troubles ..	397	2·6	13	3·8	1,018	1·5	94	2·0
Labour	..	..	..	..	..	..	..	..
Appendicitis	1	..	..	..	9	..	..	..
Accidents/Injuries ..	5,069	32·7	8	2·3	19,764	29·3	155	3·2
Miscellaneous	2,726	17·7	127	37·3	10,915	16·2	2,237	45·7
Total	15,477	100	341	100	67,443	100	4,886	100

APPENDIX VII.—Early History of the Health Insurance Proposals.*

1. The question of instituting health insurance schemes in India first came under the consideration of the Government of India in 1927 in connection with the Conventions regarding health insurance for workers in industry, commerce and agriculture, which the International Labour Conference had adopted at its 10th session. The conclusion arrived at by the Government of India then was that the Conventions were not practicable in the existing conditions. The question was discussed in the Legislative Assembly in 1928, when the Government moved the resolution that the International Conventions regarding health insurance should not be ratified. The grounds on which the resolution was based were that the Indian labour was migratory in character and that self-governing workers' organisations were absent in India. An amendment, moved by Mr. N. M. Joshi, supporting ratification, was negatived and the official resolution was adopted. But, nevertheless, the Government recognised that some sort of provision in the direction of health insurance was necessary in the interests of the worker and they, therefore, approached the Provincial Governments for views in the matter. The replies received from them were not, however, encouraging.

2. The Royal Commission on Labour discussed the question in their Report (See excerpt in Appendix VIII) and recommended that effort must be made to explore "all methods that may lead to the alleviation of the existing hardships." They recognised that there were formidable difficulties in the way, including those of following the workers to their villages, arranging for proper medical treatment there and providing medical certificates, while lack of faith in modern medical methods and heavy administrative expenses were also factors to be reckoned with. Insufficiency of statistics of sickness was another lion in the path. The Commission, therefore, suggested that, apart from collection of data from individual health insurance scheme, which could be started by private employers, preliminary enquiries might be conducted by the Government of India through an informal committee of the Central Legislature, including representatives of capital and labour who may be advised by medical and actuarial experts. Until a final and comprehensive scheme was evolved, however, the Commission recommended the adoption of an interim tentative scheme on the basis of single establishments. The principal idea of this scheme was the separation of medical from cash benefits, the former being provided by the State and the latter by employers out of funds to which both they and workers should contribute.

3. The Commission's recommendation was examined by the Government in consultation with the Standing Advisory Committee of the Central Legislature attached to the late Industries and Labour Department. The Committee had the assistance of the Public Health Commissioner on the medical aspects and in considering the form in which the statistics should be collected, the Government secured the advice of the Government Actuary's Department in London. The advice given indicated that an elaborate analysis would be required, over a series of at least five years, of the experience as regards sickness and employment of a representative sample of the industrial population. An "experience card" was, therefore, drawn up, together with a memorandum on the method of completing the cards in selected factories. The form of the card was, however, found to be too complicated and attempts to simplify it were not fruitful. The Government, therefore, found it necessary to re-examine the question and came to the conclusion that the proposed statistical enquiry would involve labour and expense out of all proportion to the probable value of the results. They stated that:—

(*a*) The maintenance of the experience cards would be a difficult and, probably, a costly task, which it would be impossible to prevail upon the employers to undertake;

(*b*) Even if the administrative and financial difficulties were overcome, statistical results obtained in the absence of benefits would be extremely unreliable, because there would be no effective check on their accuracy;

(*c*) So far as the Government of India were aware, no local Government or large body of employers were likely to institute any comprehensive scheme of sickness benefits;

(*d*) Even if there were a prospect of a comprehensive scheme being undertaken, it would be a sounder and quicker method of proceeding to institute small empirical schemes and to build on experience rather than on theory.

The Government of India, therefore, decided to pursue the idea of introducing in single establishments actual schemes of the type envisaged by the Royal Commission on Labour, wherever medical facilities could be made available by Government, provided that the employers and workers were willing to contribute. Along these lines, with the approval of the Standing Advisory Committee, they issued a fresh circular letter to the Provincial Governments in April 1935. The Provincial Governments agreed with the Government of India that the statistical enquiry would be too costly and difficult, and that the suggestion for building on actual experience of small schemes was a sounder method, but they pointed out that almost no experience was available for the purpose. In May 1937, the Government of India reluctantly came to the conclusion, which was communicated to Provincial Governments, that as there was lack of real demand for any experimental schemes on the part of the Provincial Governments and employers, and, indeed, from workers, if the schemes were to involve contributions from them, no further action was necessary.

4. The question was again revived for discussion at the First Conference of Labour Ministers held at New Delhi in January 1940. The Conference considered that the problem was not so much the lack of medical facilities as one of enabling the worker to maintain himself and his dependants during periods when he was unable to earn a living because of sickness, that sickness benefit funds would be appropriate for this purpose, and that further action should be considered after it had been ascertained how far employers and workers were willing to contribute compulsorily to such funds.

*[Mainly collected from the Bulletins of Indian Industries and Labour, No. 63, 70, 72 and 73.]

5. Accordingly, the Government of India issued a letter to the Provincial Governments and Administrations requesting them to consult important associations of employers and workers on the question of compulsory contributions to sickness insurance funds. Employers' views were typified by the following resolution adopted at a Joint Conference held in September 1940 of the Employers' Federation of India and the All-India Organisation of Industrial Employers:—

"This Conference generally approves the principle of sickness insurance provided that (*a*) the State, Employers and Labour contribute to the cost; (*b*) legislation is on an-India basis; (*c*) legislation is made applicable to all important industries and governmental undertakings, both central and provincial; and (*d*) similar legislation is concurrently enacted in all Indian States."

Some other important considerations advanced by the employers were: (*i*) that all questions of social legislation such as sickness insurance, holidays with pay and other questions of like nature should be handled together so that the interests concerned might be in a position to assess the cumulative effect of the burdens which were likely to be imposed upon them; (*ii*) that the further consideration of the question should be deferred until the end of the war. The workers' organisations also accepted the principle of compulsory contribution but urged the view that owing to low wages and the absence of minimum wage legislation in India, the worker's contribution should be nominal, the main cost of the schemes being shared between employers and Government. They also stipulated that the administration of the fund should be under the joint control of the trade unions, the employers and the Government. The Provincial Governments, on the whole, with a few exceptions were in favour of a compulsory scheme, but pointed out a number of difficulties which would arise. Opinion was divided on the question of contribution from Governments, while it was also felt that it would not be necessary to postpone the scheme till the end of the war, as it would be some time before all the details of the scheme were actually worked out and the scheme brought into force.

6. In view of the favourable response generally received from employers and workers, the matter was placed again before the second Conference of Labour Ministers held at New Delhi in January 1941. The Conference had also before it a note on the subject by the Superintendent of Insurance (See Appendix XI). Guided largely by that note, the discussions at the Conference ended in a fresh suggestion that preliminary actuarial examination should be undertaken in certain large industries before a scheme was introduced. Latterly, however, the difficulties of actuarial examination covering a wide field again become apparent, and the same objections which rendered it necessary to give up this method of approach in 1937 were advanced. The Government of India, therefore, were inclined to the view that it might be worthwhile without waiting for detailed statistical investigation to consider starting some experimental scheme to apply only to certain well-defined industries with a view partly to making a start and partly to obtaining the statistical material by utilisation of which the scheme could be subsequently finalised. The Superintendent of Insurance also informed Government that if a start was to be made without detailed statistical investigation a process of "intelligent guessing" starting from known facts from other sources was all that could be done. Provided, therefore, there was enough material for "intelligent guessing" in any industry it seemed worth consideration whether an experimental scheme might not be started and in fact the principle of gradualness was regarded as specially advisable in this field. It was considered that any such scheme should, in the first instance, be of an experimental character and should if possible, be capable of expansion or modification.

7. The subject was again brought before the Third Conference of Labour Ministers held in January 1942. The points considered were (*i*) first.y, what industry or industries should be selected for the introduction of the scheme; (*ii*) secondly, whether there would be any contributions by the State; (*iii*) thirdly, whether the scheme could be made partly non-contributory. The Government of India also placed before the Conference a tentative scheme (See Appendix IX) to serve as a basis for discussion. The Conference also considered the Bombay Textile Labour Enquiry Committee's draft scheme (For a summary, see Appendix X). Opinion was unanimous that it would be most desirable to introduce sickness insurance scheme in a tentative form if this w ere found possible. Although the employers and workers would like Governments also to contribute, it was decided to adhere to the dedision of the Second Conference of Labour Ministers that Governments should not be asked to contribute to the health insurance fund. It was, however, considered that even in a tentative scheme drawn on cautious lines it might be found, that the blance in the fund was insufficient to meet the deficits, and that even if Governments did not contribute, the alte rnative of a "guarantee" to ensure the solvency of the fund was worth consideration. Provincial Governments were not prepared at the Conference to commit themselves to such a guarantee. They were, therefore, addressed in March 1942. All Provincial Governments have been agreeable to the proposal. The Provincial Governments also agreed that, in the first instance, the scheme should be applied to the cotton and jute textiles and the heavy engineering industry.

8. The Government of India's tentative scheme placed before the Third Conference of Labour Ministers was mainly intended to provoke discussion. It was, therefore, suggested by the Government that the details of a full scheme should be worked out by a small committee of about three expers including an actuary from the Office of the Superintendent of Insurance. Latterly, however, it was deemed advantageous to entrust the work to an officer on special duty. It was decided that the officer should be assisted by the office of the Superintendent of Insurance and that he should consult Provincial Governments and also take advice from a Panel of Advisers representing employers and workers.

APPENDIX VIII.—Extract from the Report of the Royal Commission on Labour in India

(Chapter XIV.—Health and Welfare)

The question of making provision for workers during sickness, even if it had not been previously raised by Government, would have been forced on us by what we found in every industrial centre. Of the great need of the workers for something of this kind there can be no doubt. By common consent the incidence of sickness is substantially higher than in Western countries; the medical facilities are much less adequate, and the wages generally paid make it impossible for most workers to get through more than a very short period of illness without borrowing. Indeed, sickness is an important contributory cause of indebtedness with all that debt entails under existing conditions; for often, at his time of greatest need, the worker may find himself destitute of resources, unable to take proper measures to restore his health in difficulties regarding even the means of subsistence. The situation calls for the exploration of all methods that may lead to the alleviation of the existing hardships.

International Labour Conventions.

These considerations were recognised by the Government of India in 1928 in considering the Draft Conventions and Recommendations on the subject of sickness insurance which had been adopted by the International Labour Conference in the preceding year. They stated that they were satisfied that the introduction in India of any comprehensive scheme on the lines of the Conventions was not practicable in existing conditions. But, after observing that they were " in entire sympathy with the ideals " underlying sickness insurance legislation, they added " They are satisfied that the need of Indian workers for some provision is in no way less than the need of workers in other countries, and the problem, as it presents itself to them, is one of determining the extent to which the serious practical difficulties that must attend the introduction of any scheme can be overcome ". The letter containing these views was addressed to local Governments, who were asked to investigate the question, the suggestion being made that the examination might be entrusted to small informal committees of employers and employees. The results of the investigation which have been supplied to us show that five committees were appointed. The Madras committee was unable to suggest any satisfactory scheme and favoured actual experiments. The United Provinces committee favoured a scheme for a general provident fund to provide not merely for sickness insurance but for unemployment, old age, marriages, funerals, religious rites, festivities and other " social events ". The Punjab committee recommended the application of a scheme of sickness insurance, but did not enter into details. The majority of the Central Provinces committee were emphatically of opinion that any scheme of compulsory insurance was unworkable in practice. A conference held in Burma came to the conclusion that the immediate introduction of even a limited scheme was impracticable. In replying to the Government of India the Governments of the provinces in which these investigations were held all stressed the financial burdens involved in State assistance to any scheme. This was also emphasised by the Governments of the other major provinces except the Government of Bengal, who took no action in view of the impending appointment of this Commission. Neither this consideration of the question nor the further evidence supplied to us can be said to have brought a solution much nearer. There has been a tendency on the one hand to overlook the difficulties and on the other to the content with stressing them. That the difficulties in the way are formidable must be recognised. The main difficulties include following the workers to their villages, arranging for proper medical treatment there, and providing for medical certification, in order to enable workers to obtain extended benefits should sickness continue The lack of faith in modern medical methods is still an important factor and the administrative expenses likely to be incurred in working on a national or even a provincial scale of system of insurance based on Western lines would probably be extremely heavy. But none of these arguments diminish the need of the worker for provision during sickness.

Statistics of Sickness Incidence

Unfortunately, the examination hitherto given to the subject has not provided what must be regarded as an essential preliminary to the framing of a satisfactory scheme. What is required is an estimate of the incidence of sickness among workers whom the scheme is designed to cover. Without this it is impossible even to guess at the cost of any benefits which it is desired to provide or conversely, the benefits which can be secured from any given contributions. The collection of the necessary material for the framing of an estimate, therefore, is the first task which should be undertaken. The amount of material already available is extremely scanty. In response to a suggestion from us the Director of the Labour Office at Bombay kindly made an endeavour to conduct an investigation into the matter; but, having regard to the very short period of about three months over which the enquiry was made and a number of other special factors mentioned in his report, the result can hardly be taken as giving much guidance, even for the class of workers to which the enquiry related. What are required are figures showing the incidence of sickness for definite groups of workers over a comparatively long period, and it is unlikely that such figures will be easy to obtain. The railways and Government factories, most of which have schemes for the grant of leave on account of sickness, may be able to give some assistance; but in both cases workers are generally engaged after medical examination and thus represent a selected class. A number of employers have sickness benefit schemes, and their co-operation might be secured. It would be of special assistance if a few employers would agree to make experiments in the grant of sickness benefits either on a contributory or on a non-contributory basis, and to maintain record of their experience. But assistance secured from these sources will almost certainly require to be

supplemented by special statistical enquiries in selected centres, and we recommend that these be instituted as soon as possible. The collection of the statistics should be made with expert medical and actuarial advice and with the co-operation of persons qualified either as employers or as representatives of labour. The preliminary enquiries might be conducted by the Government of India who might secure for the purposes from the Central Legislature a small informal committee, including representatives of capital and labour. These, with medical, actuarial and statistical assistance, should be able, to advise regarding the nature of the statistics required, the centres in which they might be collected, the sources from which they should be obtained, and the means of obtaining them.

A Method of Attack.

We recommend that, thereafter, the question of framing schemes be referred to a carefully selected formal committee who might be instructed to examine the material and to make recommendations for the institution, if and where possible, of definite schemes. In the first instance, it may prove advisable to start on a small scale with a view to gaining experience. In instituting measures of this kind, there is a greater possibility of achieving success by building on an existing foundation than by introducing methods which are entirely foreign to the country. The British sickness insurance scheme, for example, was built on the broad foundation of the Friendly Societies with their years of accumulated experience. Nothing of the kind is in existence in India. On the other hand, there is, in certain directions, the nucleus of a different form of provision for medical and financial relief in cases of sickness Government and many private employers already provide medical facilities. In addition, most Government establishments make provision for the grant of leave with pay which can be utilised when the worker is sick. A few employers make some provision for the grant of sick pay and allowances, *e.g.*, the Bihar and Orissa Government stated in 1929 that in the Jharia and Raniganj coalfields, out of 214 working mines, 68 paid sickness allowances. Although the proportion of workers serving private employers who are provided with sickness benefits is extremely small, the Government schemes have made the idea fairly familiar in India. These schemes are bon-contributory, but we have no reason to believe that the collection by employers of reasonable contributions from workers will be a matter of serious difficulty. Pursuing this line, we proceed to give the outline of a possible scheme and commend it for examination.

A Tentative Scheme.

This scheme is based on the assumption that responsibility for the medical and for the financial benefits will be separated. The former could be undertaken by Government, possibly on a non-contributory basis, and the latter through employers on the basis of contributions by themselves and by the workers. In India, the extension of medical facilities by the State offers advantages which are less likely to be secured by a scheme of private medical service based on a system of insurance, and the need of such extension is everywhere evident. It should not be difficult to devise arrangements whereby such medical services as are maintained by private employers may continue to operate in conjunction with a State scheme. Public expenditure directed towards the assistance of private schemes might in many cases produce more substantial results than equivalent sums devoted directly to state provision. So far as sick allowance are concerned, the employer might be required to deduct a certain percentage of wages to credit this to a fund, and to add thereto contributions of an equivalent amount, or rather more in the case of the more poorly paid. Workers who had contributed to the fund or a minimum period, *e.g.*, one year, might, if certified as sick and likely to remain so for more than specified short period, be granted sick leave. Provision might have to be made for some refund to those workers who left employment after subscribing and before they had been covered by the insurance for a reasonable period. The period of leave need not bear a strict relation to the duration of the illness, but could be fixed on some arbitrary lines, *e.g.*, to begin with, a fortnight in some cases and a month in others, and it would be subject to an absolute limit, *e.g.*, one month in any year. During the period of sickness, the worker would be entitled to a proportion of his wages which would be paid from the fund by the employer. In the initial stages it would be possible for the employer to appoint the medical officer who would grant certificates, but it would be necessary to ensure that the employer was not in a position to benefit from the accumulation of a balance in the fund. The supervision, and audit of funds by the State would be necessary. After providing a suitable reserve for epidemics and other emergencies, the balance could be devoted towards increasing the annual period of sick leave that could be granted. Similarly, if on account of the number of claims, the income of the fund proved unequal to the expenditure, it would be necessary to reduce the periods to secure solvency. Such schemes could operate on the basis of single establishments, where these wre large enough and small establishments might be combined for the purpose.

Medical Attendance and Cash Benefit.

By the time the statistical material has been collected, it may be possible for a more complete scheme to be devised. The main question to be considered at this stage will be how far medical attendance and cash benefits can be correlated. If the two were kept separate, it would be a reasonable criticism that those workers who did not utilise the medical facilities provided were increasing their claims on the fund at the expense of others. On the other hand, in some cases a return to the worker's village is likely to be of as much benefit to health as medical attendance in the city, and the keeping of the two branches of relief entirely independent would eliminate the difficulties that would arise if the period of leave could be extended by supplementary medical certificates.

APPENDIX IX.—The Labour Department Scheme.

(Placed before the Third Conference of Labour Ministers.)

(In paragraphs 1 to 5 " factory " refers only to any factory to which the scheme applies.)

1. Each factory shall be required to appoint one or more medical officers who shall attend at the factory or neighbouring dispensary for the purpose of certification. The factory shall also be required, unless exempted by the Provincial Government, to provide to the satisfaction of the Provincial Government adequate arrangements for medical treatment at the factory.

2. A factory be required to pay to any of its permanent employees, whose pay does not exceed Rs. 100 and whose name has been on their books for a period in excess of six months after the introduction of the scheme, benefits at the following rates for the fourth to the eighteenth day of certified sickness—Certified sickness shall be sickness certified as such by the medical officer of the factory—

(*i*) Benefits at half daily wages subject to a minimum of 8 annas a day or 3/4th of daily salary whichever is less and a maximum of annas 12.

Note 1.—Medical certification by a medical officer appointed by the factory is clearly open to objection (particularly perhaps in the non-contributory part of the scheme), but the alternative of making the fund pay for such certification is, it is considered, initially impracticable.

2. Medical certification only in the neighbourhood of the factory precludes in most cases payment of benefit where the employee proceeds to a distant home.

(*ii*) Employers to be required to subscribe monthly by deductions from their salaries the following amounts—

Those drawing a daily wage of less than annas 13—*Nil.*

Those drawing a daily wage of over 13 annas at the rate of 0-0-9 for each complete Rs. 5 of wages drawn within the month subject to a maximum of 6 annas in the case of those drawing under Rs. 50 and of 9 annas in case of those drawing over Rs. 50.

Subscriptions would be payable for the first six months after the introduction of the scheme during which benefits were not payable.

3. Each factory will be required to meet the whole cost of benefits paid to non-contributory employees and these benefits shall not be a charge on the contributory fund.

4. Each factory will be required to keep an accurate account of the receipts from contributory employees and the payment to contributory employees. It is intended that half benefit paid shall be at expenses of millowner ; if therefore any mill's receipts exceed half the sum paid as benefit the mill will be required to fund any excess of receipts over half expenditure for the purpose of lengthening the period of benefits.

5. Each factory will be required to maintain statistics in the prescribed form.

APPENDIX X.—The Bombay Textile Labour Enquiry Committee's Scheme for the Bombay Province.

(Reproduced in the form of a portmanteau quotation from the Committee's Report).

" .... Many countries, which wished to introduce social insurance schemes in the past, began by starting special compulsory insurance schemes for miners, seamen, railwaymen and workers in large industrial undertakings that appeared to lend themselves most easily to the introduction of social legislation, and this Province can well make a beginning in the direction with the cotton textile industry. In instituting measures of this kind, we would advocate the adoption of the approach which has proved successful in other countries. This becomes all the more necessary when it is found to be practically impossible to collect any reliable morbidity statistics for framing scientific sickness insurance schemes for this Province. We feel that the absence of reliable morbidity statistics and the difficulties in the way of instituting an inquiry into the incidence of sickness should not be allowed to stand in the way of the introduction of a scheme of sickness insurance for the cotton textile industry in this Province. Much valuable statistical and other material on the different aspects of health insurnce schemes in foreign countries, for example, their scope, administration, financial resources, benefits, average cost per insured person, has become available during the last twelve years. We believe that a careful study of the working of the different sickness schemes introduced in various countries, including that of an Eastern country like Japan, should make it possible to start in this Province a modest scheme on the usually accepted lines. The main feature of such schemes is that they are elastic and that as experience is gathered and the funds grow in size the benefits may be extended....

Essential Features of Sickness Insurance.

Any sickness insurance scheme to be introduced in this Province must be on a contributory and compulsory basis.... We are of the opinion that the scheme should be very simple in character at least in its initial stages and that both the contributions and the cash benefits payable under it should be fixed on a flat rate basis as in the British Health Insurance Scheme. The scheme should be restricted to permanent workers in cotton textile factories and should be introduced first in Bombay and Ahmedabad. It should be under the control of a Central Board of Management consisting of representatives of

Government, local bodies, employers' and workers' interests and of the medical profession. Expenditure in connection with the Board and its establishment should be borne by the Provincial Government. We recommend the following benefits under the scheme :—

(*i*) Medical benefit consisting of free medical treatment and attendance and free medicines and appliance. The insured persons should be entitled to medical benefit immediately after the payment of the first insurance contribution and they should also received free medical certificates for health insurance purposes from the doctors appointed under the scheme.

(*ii*) Cash benefit commencing from the fourth day of incapacity and continuing for a period or periods up to a maximum of six months in a year at a flat rate, but not exceeding 75 per cent. of the insured person's average daily wage during the preceding quarter.

(*iii*) Additional benefits as may be decided upon by the Central Board of Management from time to time according to the availability of surplus funds.

The cash benefit should ordinarily be payable to the workers in the towns in which they are employed but not in cases where compensation for accidents or maternity benefits are provided for the insured persons under the Workmen's Compensation Act, 1923, or the Bombay Maternity Benefit Act, 1929. The Central Board of Management may, however, allow the insured person, even if he temporarily leaves the town of his employment, to draw sickness benefits either at full or at reduced rates, provided he produced, in a manner to be prescribed, satisfactory evidence of his continued incapacity during the period for which the benefit is claimed.

The principles of joint contributions by the employers and the employees to social insurance funds is now being increasingly adopted in most countries..... Even in India the principle of contributions by employers has already been recognised in the Workmens' Compensation and the Maternity Benefit Acts. In other countries the State also contributes a share to social insurance funds in varying proportions either for meeting the cost of the benefits or for administrative expenses.... Though there is no uniformity in the apportionment of the contributions between the employer, the worker and the State, it is now generally recognised that, in the case of workers whose wages are low, the employer's share should be larger than that of the workers.

....The insured workers' share of the contributions should be deduted from their wages by the employers who should be held responsible for the payment into the sickness insurance fund of the total contributions of all the insured workers employed in their factories. By way of illustrating the manner in which a scheme of sickness insurance can be worked out in accordance with the general principles formulated by us, we give below the approximate calculations of such a scheme on a tentative basis.

Illustrative Scheme.

The monthly contributions payable by the employers, the employees and Government may be at the following rates, subject to the condition that the rate of contribution of the insured person shall in no case exceed five per cent. of his or her average monthly wages during the preceding quarter :—

	Monthly contribution payable by :—			
Insured worker.	Employer.	Worker.	Government.	Total.
Male	As. 10	As. 5	Anna 1	Re. 1
Female	As. 10	As. 4	Anna 1	As. 15

These rates are at a much lower level than those suggested by Mr. Stones in the course of his evidence, namely, eight annas per month per adult worker with a contribution by the employer of one rupee per month, as we are of opinion that it is desirable to make a beginning on the basis of a scale of payments by the employers which does not impose an unduly heavy burden on the cotton mill industry. Because of the same consideration the cash benefits may be placed at the following rates :—

Period.	Daily cash benefit from the fourth day of incapacity. Men.	Women.
(*a*) During first six months after entering insurance	*Nil*	*Nil*
(*b*) After completing six months' insurance period any payment of of six monthly contributions but before completing 24 months' insurance period	As. 6	As. 5
(*c*) After completing 24 months' insurance period and payment of 24 monthly contributions	As. 10	As. 8

Medical benefits consisting of free medical attendance and the free supply of medicines form an essential part of a sickness insurance scheme. The system to be adopted for providing medical attendance to the insured persons during times of illness, therefore, requires careful consideration. Medical attention is provided in England through what is known as the panel system.... We recommend that the same principle should be adopted in this Province, We may calculate the cost of free medical attendance on the basis of Rs. 3/- per annum for each insured person and this would cover all medical and surgical attendance at the homes of the insured when necessary, the issue of free medical certificates for health insurance purposes and the maintenance of proper statistical records. We have already recommended that there should be no waiting or qualifying periods for medical attendance on the insured and this should begin simultaneously with the entry of the insured person on the list of a panel doctor .... "

APPENDIX XI.—A NOTE ON SICKNESS INSURANCE

BY

Mr. J. H. Thomas, former Superintendent of Insurance.

The proposal to establish a system of sickness insurance in India raises many problems of a very intricate nature which must receive the closest attention before any concrete proposals should be published.

2. I have been asked to submit a note on the proposal and mention below a number of points that occur to me. I should make it clear, however, that my knowledge of the subject is confined to the system of National Health Insurance in the United Kingdom and that my experience of that system gained in the Government Actuary's Department, London, was not of a detailed or specialised nature and did not bring me into very close contact with the scheme. Before the sytem was adopted in United Kingdom British Government engaged the services of two consulting actuaries for the purpose of preliminary investigations, and many months passed before the proposals were made public. If the Government of India decide to proceed with a scheme, it would seem necessary for them to contemplate similar investigations by competent persons having practical experience. In this connection it may be mentioned that within the last three or four years the Governments of New Zealand and of the Commonwealth of Australia have both followed this course and secured the services of members of the Government Actuary's Department, London, who had specialised experience in the administration of National Health Insurance.

3. I now turn to a consideration of the points that occur to me and deal with each under a separate paragraph.

4. *Classes of persons to be insured.*—Since contributions and benefits have to be equated it follows that default in payment of the former must entail loss of benefits, either partial or total. Consequently it is essential that only those industries in which employment is reasonably constant and continuous should be included. Seasonal occupations should be excluded at least until the system is well-established.

5. *Machinery of administration.*—In the United Kingdom this was grafted on to the old-established Friendly Society and Collecting Society system, and so, broadly speaking, only the central co-ordinating authority was required. This duty fell to the newly-formed National Healthe Insurance Commission which was later absorbed by the Ministry of Health. I think it may be claimed that much of the success of the scheme in United Kingdom has been due to the adoption of the Friendly Society system as a framework. Indeed, the Royal Commission of 1924 reported that the system had justified itself. By its means close and intimate contact between insured and the administration is achieved, with the result that the insured take a more personal interest in the prosperity of their "approved society" and direct or indirect frauds upon it are made more difficult. In India there is no Friendly Society system and the local machinery will therefore have to be set up for the purpose by Government, or as a possible alternative, the Trade Unions might be considered. There would still remain the central co-ordinating administration to be established.

6. *Benefits.*—In the United Kingdom no benefits of any sort were payable for the first six months after the inception of the scheme so as to allow a fund to be accumulated out of contributions.

The benefits are :—

(*a*) *Sickness benefit* at the statutory rate for the first 26 weeks.

(*b*) *Disablement befiefit* at half the sickness rate for so long after as the incapacity continues.

(*c*) *Maternity Benefit* consisting of a lump sum payable to a contributor whose wife is confined or to the female contributor if she is confined. Double benefit is payable if both husband and wife are contributors.

(*d*) *Medical benefit.*—This covers medical attention and simple medicines. Benefits (*a*) and (*b*) can only be drawn after medical certificates of incapacty by the doctor are obtained and renewed if necessary, at stated intervals.

(*e*) *Cost of administration.*—This has to rank as a benefit as it is provided out of the contributions. It will be noticed that there is no death benefit.

7. *Medical charges.*—Duly qualified medical officers are eligible to have their names put on local medical panels and the insured person is allowed to select his own attendant to whom he must adhere, but arrangements are made for transfer at reasonable intervals. Each doctor receives a flat rate per annum for each contributor on his books whether or not the contributor is sick. Other suitable arrangements are made for medicines.

8. *Administration charges.*—These are at a flat rate per head and are disbursed so as to recoup the local administrative units. The expenses of the central authority are borne by general revenues.

9. *Additional benefits.*—Under the United Kingdom system each "unit" or "approved society" as it is called, is periodically valued by the Government Actuary's Department and any surplus declared divisible may be utilised for increasing the cash benefits or givng non-cash benefits, such as dental or opthalmic treatment which are not included in the normal statutory benefits. A deficiency results in reduction of the statutory benefits.

10. *Contributions.*—In the United Kingdom system there are three contributories :—

(1) The employee,

(2) The employer, and

(3) The State.

The first two pay about equal shares, but the State's contribution takes the form of an annual grant equal to a percentage of the actual expenditure on benefits. This percentage has often been varied, but the limits of variation, as far as I can recollect, have been between 15 per cent and 25 per cent.

11. *Incidence of earnings on contributions and benefits.*—The principle of the United Kingdom system is that it aplies to all manual workers rgardless of earnings, but only to non-manual workers below a certain limit of remuneration.

Subject to reduced benefits as a result of default in payment of contributions it may be said that the rates of benefit and contributions are flat, i.e., that earnings are not taken into account. It should be mentioned, however, that a few occupations presenting special features have required special treatment, but it would seem inadvisable to introduce these complications in India at least, at the outset.

My own view is that differential rates of benefits and contributions should be avoided. Not only do they introduce great complications into the administration but they also affect the financial baiss in the sense that they require the introduction of undesirable assumptions into the mathematical calculation underlying the scheme. It is submitted that the difficulties of starting a scheme in India are in themselves so great that it is undesirable that this complication should be introduced at the outset ; the U.K. scheme, for instance, makes no difference between manual workers, no matter what their earnings, and this would seem to be a case where the Government of India should be content with a scheme on the simplest lines, at least until there are some staistics available in relation to Indian experience.

12. *Method of collection of contributions from employer and employee.*—The stamped card system is used in the United Kingdom. The onus of stamping is on the employer who has the right to recover the employee's portion from his wages.

13. *Reserve values.*—The principle of any insurance scheme, life or sickness, is that the insured pays a contribution which at the entry age is sufficient to meet the benefits as they emerge. Consequently, when an employee joins the scheme at an age later than the normal age of entry to employment, his contributions, if they are at the flat rate, are insufficient to meet the statutory benefits. At the inception of the scheme there will be many thousands of employees embraced whose ages are in excess of the normal entry age at which contributions and benefits are equivalent, and in the aggregate the scheme will be saddled at its inception with a very heavy load of liability in respect of those people. In the United Kingdom this situation was met by the crediting of "reserve values" to the approved societies — paper assets — of sufficient amount to enable them to meet the deficits arising from those entrants at ages above the normal. To redeem these paper assets a very small deduction from each contribution was diverted to a sinking fund designed to convert these paper assets into cash after a lapse of about 20 years. Other considerations arise in connection with Reserve Values but sufficient has been said to indicate the nature of the problem and the method of its treatment in the U. K. scheme.

14. *Indian sickness rates.*—I have left to the last what is undoubtedly the most baffling difficulty that will confront those who have to conduct preliminary investigations. It is the absence of existing rates of sickness, issue, and mortality on which to base the estimates. It is quite evident that British rates will be useless as a guide, and though it may be found on enquiry that some Indian institutions or organisations may have statistics to offer, it is necessary to bear in mind the psychological phenomenon proved by experience that sickness rates derived from the experience of certain body of persons when there was no sickness benefit payable, undergo considerable and unfavourable change when the same body of persons become eligible for benefit of some form or another. It may be stated as a corollary to this that no scheme should provide benefits which make it as profitable to malinger as to be at work, and in assessing "profits" for this purpose the case must not be overlooked of the man who prefers idleness under the guise of sickness with small cash compensation to work with full wages.

15. The foregoing sketches briefly the main characteristics of the U. K. scheme and it will be observed that the cardinal principle on which it is founded is financial soundness, as a result of which no burden falls on the State apart from the freely assumed obligation to contribute a fixed percentage of the actual benefits paid and the cost of the central administration. Before profitable investigations can be undertaken the broad outlines of the scheme desired for India must be decided upon. I would stress particularly the need for simplicity and for confining its scope in the first instance to a few of the better organised industries, but these must nevertheless be ones not subject to a seasonal employment. In this connection I would emphasise again my remarks in the latter part of paragraph 11.

Finally, I may add that however skilled the persons engaged to conduct the preliminary investigations may be, their task in this country where there is no known experience on which to work will be of the greatest difficulty, and after a few years of working the scheme may be found to require even considerable adjustment to maintain solvency. It should therefore be contemplated clearly as experimental in its early years.

APPENDIX XII.—SCHEDULE OF ADDITIONAL BENEFITS.

1. An increase in the rate of cash benefit in the case of either all insured persons or such of them as have dependants.

2. A prolongation of the period for which cash benefit is obtainable to different classes of workers.

3. Allowances to a member during convalescence from some disease.

4. The payment of the whole or any part of the cost of medical or surgical advice or treatment by any registered medical practitioner, not being advice or treatment within the scope of any other additional benefit or medical benefit.

5. The payment of the whole or any part of the cost of the provision of dental treatment (other than as provided as part of medical benefits.)

6. The payment of the whole or any part of the cost of the provision of opthalmic treatment (other than as provided as part of medical benefit) and the whole or any part of the cost of optical appliances.

7. The payment of the whole or any part of the cost of medical and surgical appliances other than dental and optical appliances and those provided as part of medical benefits.

8. The payment of the whole or any part of the cost of medical treatment in the case of tuberculosis, venereal diseases and any other diseases which have been specifically excluded from this Scheme.

9. Payment of full cash benefit or cash benefit at a higher rate than that provided under the Scheme to insured persons receiving hospital treatment.

10. Payments to hospitals in respect of the maintenance and treatment therein of insured persons and the payment of the whole or any part of the travelling expenses incurred by or in respect of members in travelling to and from hospitals.

11. The payment of the whole or any part of the cost of maintenance and treatment of the insured persons in convalescent homes and the payment of the whole or any part of the travelling expenses incurred by or in respect of members in travelling to and from convalescent homes.

12. Provision of benefits to the members of insured persons' families.

13. Provision of medical benefits to persons crossing the upper age-limit.

14. Payment of the whole or any part of the cost of provision of nurses to insured persons.

15. Payment to members not allowed to attend work on account of danger of infection.

16. Repayment of the whole or any part of the contribution payable under the Act by insured persons.

17. Provision of benefits to the unemployed.

18. Payment to or on behalf of insured persons who are in want or distress.

19. Payments to approved charitable institutions in respect of any treatment of insured persons required for the prevention or care of disease, not being treatment within the scope of any other Additional Benefit or Medical Benefit.

20. Construction of hospitals, sanatoria and convalescent homes, and purchase of medical appliances for their use.

21. Erection of special clinics for the excluded diseases such as tuberculosis, cancer, leprosy, venereal diseases, etc.

22. Provision of Funeral Benefit.

23. Such other Additional Benefits, being of a character similar to that of any of those hereinbefore mentioned, as may be prescribed.

APPENDIX XIII—Morbidity Experience Abroad.

TABLE 35.—*English Morbidity Experience (Men)**

Age last birthday at beginning of year.	Rate of Sickness per annum.		First six months of Incapacity (Men).		
	National Health Insurance, Sample Experience, 1921-23. (Weeks).†	Manchester Unity of Oddfellows Experience, 1893-97. (Weeks).‡	Manchester Unity of Oddfellows' Experience, 1866-70. (Weeks)	Registered Friendly Societies' Experience, 1876-80. (Weeks)	Ancient Order of Foresters' Experience, 1871-75. (Weeks)
16—19 ..	0·63	0·92	0·54	0·77	1·04
20—24 ..	0·67	0·79	0·75	0·76	0·82
25—29 ..	0·67	0·80	0·81	0·74	0·85
30—34 ..	0·71	0·85	0·93	0·84	0·97
35—39 ..	0·75	0·94	1·06	0·94	1·15
40—44 ..	0·80	1·07	1·26	1·08	1·37
45—49 ..	0·90	1·23	1·64	1·28	1·71
50—54 ..	1·10	1·47	2·22	1·52	2·27
55—59 ..	1·39	1·83	3·05	1·87	3·21
60—64 ..	1·85	2·30	4·72	2·51	4·59

*Compiled from *National Health Insurance: A Statistical Review*, by Sir Alfred W. Watson, in the *Journal of the Royal Statistical Society*, Vol. XC, Part III, 1927, and the *Actuarial Report on the National Scheme of Insurance against Sickness, etc.*, by Hardy and Wyatt in the *Journal of the Institute of Actuaries, July 1911.*

†Sickness rate has been adjusted to cover all incapacity from the first day for comparative purposes.

‡National Health Insurance Scheme was based on this experience.

TABLE 36.—*English Morbidity Experience (Men and Women).**

Age last birthday at beginning of year.	Rate of sickness per annum. First six months of incapacity. (National Health Insurance Sample Experience, 1921-23).		
	Men.	Women.	
		Spinsters and Widows. (Weeks).	Married Women. (Weeks).
	(Weeks).		
16—19	0·63	0·79	3·84
20—24	0·67	0·87	2·35
25—29	0·67	0·85	1·74
30—34	0·71	0·87	1·53
35—39	0·75	0·91	1·54
40—44	0·80	1·01	1·58
45—49	0·90	1·14	1·67
50—54	1·10	1·29	1·83
55—59	1·39	1·48	2·01
60—64	1·85	1·83	2·44

* Quoted from Sir Alfred W. Watson, *op. cit.*

NOTES :— (*i*) As in the case of men, the sickness rates of women have been adjusted to cover all incapacity from the first day.

(*ii*) Sickness rates of women have been compared with corresponding figures of men, for no "pre-Act" figures of any worth, for women, exist.]

TABLE 37.—*Morbidity Experience of the Different Countries (Men)**

Annual Morbidity Rate in Days.

Age.	Kinkolin's table.	Moser's table.	Janse's table.	Austrian table.	English actuaries' table.
16	6·32	6·87	..	7·6	6·57
17	6·16	6·65	..	7·8	6·44
18	6·02	6·36	..	7·9	6·21
19	5·89	5·90	..	8·2	5·94
20	5·78	5·39	4·50	8·4	5·70
21	5·68	5·12	4·55	8·3	5·52
22	5·60	4·96	4·60	8·0	5·41
23	5·53	4·88	4·64	7·7	5·38
24	5·47	4·84	4·69	7·8	5·38
25	5·44	4·85	4·74	7·9	5·41
26	5·42	4·88	4·84	7·8	5·43
27	5·41	4·98	4·93	7·8	5·45
28	5·42	5·11	5·00	7·8	5·51
29	5·44	5·25	5·08	7·8	5·58
30	5·48	5·41	5·16	7·9	5·66
31	5·53	5·61	5·16	8·0	5·75
32	5·60	5·83	5·39	8·1	5·86
33	5·68	6·05	5·50	8·3	5·96
34	5·78	6·27	5·70	8·4	6·07
35	5·90	6·48	5·91	8·5	6·20
36	6·03	6·67	6·11	8·7	6·34
37	6·17	6·84	6·29	8·8	6·50
38	6·33	6·99	6·45	8·9	6·69
39	6·51	7·12	6·64	9·0	6·88
40	6·70	7·24	6·84	9·2	7·08
41	6·90	7·36	6·95	9·3	7·30
42	7·12	7·49	7·10	9·4	7·51
43	7·36	7·63	7·29	9·6	7·73
44	7·61	7·78	7·45	9·8	7·94
45	7·88	7·96	7·60	10·1	8·16
46	8·16	8·18	7·75	10·3	8·41
47	8·45	8·46	7·95	10·6	8·71
48	8·76	8·82	8·22	10·9	9·03
49	9·09	9·27	8·47	11·2	9·38
50	9·43	9·82	8·70	11·5	9·77
51	9·79	10·41	9·15	11·9	10·14
52	10·16	11·02	9·60	12·2	10·55
53	10·55	11·65	10·10	12·5	10·98
54	10·95	12·28	10·77	12·9	11·47
55	11·37	12·92	11·45	13·3	12·03
56	11·80	13·56	12·20	13·7	12·59
57	12·25	14·20	12·90	14·2	13·21
58	12·72	14·82	13·67	14·8	13·85
59	13·19	15·48	14·46	15·5	14·52
60	13·69	16·12	15·34	16·2	15·25
61	14·20	16·76	16·20	16·9	16·04
62	14·72	17·40	17·00	17·7	16·86
63	15·26	18·04	17·70	18·5	17·70
64	15·81	18·68	18·48	19·0	18·55
65	16·38	19·32	19·26	19·8	19·38
66	16·97	19·96	19·95	20·6	20·26
67	17·57	20·61	20·74	21·2	21·14
68	18·18	21·26	21·80	21·9	21·99
69	18·81	21·92	23·50	22·6	22·72
70	19·46	22·59	25·80	23·2	..

*Quoted from *Compulsory Sickness Insurance* (I.L.O., 1927, pp. 440-441).

NOTES.

Kinkolin's table (*Las Societee de secours mutuels de las Suisse en 1880*, Berne, 1886) is based on the experience of 919 Swiss insurance funds operating in 1880. Benefit was payable from the beginning of the sickness for a maximum period of eighteen months (one-third of the funds insured both men and women; the remainder only men.)

Moser's table (*Report to the Third International Congress of Actuaries*, Paris, 1900) is based on the experience of the Bernese Cantonal Sickness Insurance Fund during a period of some years. Benefit was granted for not more than one year. The insured persons were selected. The number of days of sickness observed as 239,341, the approximate membership of the institution was 11,000.

Janse's table (*Report to the third International Congress of Actuaries*, Paris, 1900) is based on the observations made from 1888 to 1897 by the Amsterdam General Sickness Fund.

The Austrian table (*Krankheits—and Sterblickkeitsverhaltnisse bei den Krankenkassenin den Jahren* 1896-1910', Vienna 1913) together with that of the English actuaries, is the most interesting from the point of view of compulsory social insurance. It is based on the observations made from 1906 to 1910 for the Austrian compulsory insurance funds, covering an annual average membership of two million insured persons and a total of about ninety-five million days of sickness.

The English actuaries' table (*Report for 1912-1913 on the Administration in England of the National Insurance Act*, Part, 1, p. 383) is a variant of the table constructed by Watson on the basis of the experience of the "Independent Order of Oddfellows Manchester Unity" Friendly Society from 1893-1897. In the cases to which the figures here reproduced relate the maximum benefit period was six months. The first three days of sickness are excluded. (For the modifications introduced in Watson's table, compare the study on the technical principles of the financial system of insurance in Great Britain in this Chapter.) Watson's table (*An Account of an Investigation of the Sickness and Mortality Experience of the I. P. O. F. Manchester Unity during the Five Years 1893-1897*. Manchester. 1903, pp. 122 and 213) covered nearly three million years "exposed to the risk", and nearly twenty-four million days of benefit, with a maximum benefit period of 26 weeks and no waiting period. It should be observed that these tables were based on a six-day week, one sixth of the weekly benefit being paid for each working day. There is no similar experience relating to women.

Considering the diversity of the groups and the different definitions of the observed phenomenon, these tables are on the whole in remarkable agreement. It will be observed that, except in Janse's table, the morbidity rate reaches a minimum at about 25 years.

TABLE 38.—*Austrian Morbidity Experience, Women.**

Age.	Annual Morbidity Rate in Days. Excluding confinements.	Including confinements.	Age.	Excluding confinements.	Including confinements.
16	6·7	7·1	44	9·5	10·0
17	6·8	6·5	45	9·8	10·1
18	7·0	8·3	46	10·0	10·3
19	7·2	9·1	47	10·2	10·4
20	7·4	10·0	48	10·5	10·6
21	7·6	10·8	49	10·8	..
22	7·8	11·4	50	11·0	..
23	8·0	11·9	51	11·3	..
24	8·1	12·1	52	11·5	..
25	8·2	12·3	53	11·7	..
26	8·2	12·4	54	11·9	..
27	8·2	12·5	55	12·1	..
28	8·4	12·4	56	12·2	..
29	8·4	12·3	57	12·4	..
30	8·1	12·1	55	12·6	..
31	8·5	12·0	59	12·9	..
32	8·5	11·9	60	13·2	..
33	8·6	11·7	61	13·6	..
34	8·6	11·5	62	14·1	..
35	8·7	11·4	63	14·6	..
36	8·7	11·2	64	15·1	..
37	8·7	11·1	65	15·7	..
38	8·7	10·8	66	16·2	..
39	8·8	10·5	67	16·7	..
40	8·8	10·3	68	17·2	..
41	8·9	10·1	69	17·7	..
42	9·1	10·0	70	18·1	..
43	9·3	10·0			

* Quoted from *Compulsory Sickness Insurance*, pp. 442.

NOTES

The Austrian table is, so far as is known, the only table which is based on a sufficiently wide experience to make reproduction worth while. The period of observation is the same as that for the table of male morbidity. It covers an average annual membership of 650, 000 insured women and nineteen million days of sickness, which figure includes about six million days for 218,070 confinements.

According to Moser (*Report to the third International Conference of Actuaries*, Paris, 1900), the experience of the Bernese Cantonal Fund showed that number of days of sickness for women was 37 per cent above that for men.

TABLE 39. *Japan—Statistics of Sickness Incidence.*

	Number of days of sickness for which benefit was paid.		
	1932.	1933.	1934.
Absolute number	10,804,388	12,082,888	14,019,146
Average per insured male	7·46	6·99	7·06
Average per insured female	4·77	4·67	4·48
General Average	6·28	6·03	6·02

**International Labour Review*, Vol. XXXIII, p. 242, and Vol. XXXVI, p. 88.

APPENDIX XIV.—THE STAMPED CARD SYSTEM.

A.—*Description of the Various Cards.*

Separate cards will be required to record contributions, benefits and arrears of contributions. In general, the card system in Great Britain may be followed with advantage, though suitable modifications will be necessary in the light of special circumstances prevailing here.* In Great Britain, for example, the contributions have been classified not only according to sex and age, but also as voluntary contributors, low wage earners, exempt persons, foreign-going mercantile marine, sailors, soldiers and airmen. Further, health insurance is linked up with pensions and disablement, while the existence of approved socieities complicates matters still more, because of bifurcation of all matters regarding contributions and benefits between these societies and the Ministry of Health. Under the present scheme, there is no differentiation according to sex or age, and hence separate cards for men, women and children will not be required. Detailed instructions to insured persons and employers as regards the issue, use and surrender of cards and rules relevant to these should be printed on the cards in English and, perhaps, in the local languages. The difficulty of illiteracy and of multiplicity of languages will not be so great as would appear. It has been found that the workers can easily follow the *ration-card* system recently introduced for distribution of food in various towns in India. They can also manage without difficulty their postal bank accounts. There is no reason to suppose, therefore, that workers would experience any great difficulty in the present case. Morevoer, a special effort will be made by the Propaganda Branch to educate the workers in the rules of health insurance.

Detailed rules and featuers of the various cards will be a matter of the future. However, the procedure and purpose of some of them may be briefly stated :—

(1) *Contributoin Cards.*—Contributions will be collected according to the stamped card system. The local office of the heatlh insurance Centre or Sub-Centre will issue contribution cards to insured persons in the area. The prescribed time for the renewal of these cards will be at or before the expiration of the period of their currency. However, new cards may be issued at other times in certain circumstances, such as when a worker enters insurable employment for the first time, when cards are damaged, lost or destroyed, etc. In every case, the employed contributor must send in an application for a card to a local office.

Stamps of the requisite amounts will be printed and will be saleable at the offices of health insurance (if not, even at Post Offices). The employer will simply affix the stamps periodically to the Contribution Card of each insurable worker, and cancel them.

(2) *Record Cards.*—These cards, recording particulars of contributions and arrears and such other matters as may be prescribed, are to be issued along with the contribution cards to the insured persons. As for the issue and surrender of these cards, mostly the same rules as in the case of contribution card will apply. At the end of its currency, the card, along with the stamped contribution card, should be handed over to the Centre or Sub-Centre Office. The card will contain columns for four years or so, with such particulars as the number of contributions paid, contributions excused, arrears due and paid etc.

(3) *Benefits Record Cards.*—On making an application, an insured person wiill be supplied with a statement of his benefit record by the Centre or Sub-Centre, from which he will be entitled to claim cash and medical benefits. The currency of the card will be only for a year and it will be supplied to the insured only once during that period. All benefits received during the year will be recorded on the card. There will also be a record of the kinds of benefits provided.

*The future social security programme may no doubt include several other schemes, apart from the present one, and the Planning Committee to be appointed may recommend some sort of unified scheme of social insurance. In that case, much economy may be secured by requiring a few cards for the joint contributions to be paid and benefits to be made available to workers. It is, however, difficult clearly to foresee all the developments and hence it is possible to indicate what may have to be done for health insurance only.

(4) *Arrears Card* (Notice of Arrrears).—Once in a year, before a prescribed date, notices of arrears will be sent to insured persons. The notice will contain particulars of the number of contributions paid and excused on account of duly notified sickness and proved unemployment and the number of contributions still to be paid. An Arrears Table showing the extent of reduction in benefits in proportion to the arrears of contributions will be printed on the Arrears Card. The manner of paying the arrears will be by affixing stamps to the extent of the arrears on the space provided for that purpose, and at the time of surrender of the duly stamped card to the Centre, it should be deemed that all arrears have been paid. If an insured person fails to get a card in proper time, or he has to make corrections as to number of weeks of sickness and unemployment, he should inform the Centre within two months from the date prescribed for despatch of the cards. No evidence should be accepted after that period.

B.—*Health Insurance Registers.*

The Offices of Centres and Sub-Centres will keep registers and accounts. These will be the prototype of the cards held by the insured. Though it is not possible at this stage to give all details of the registers, a rough indication may be given here. The following list, based on the lists of books and accounts kept by approved societies and insurance committees in the United Kingdom, may be found useful.

(*a*) A general cash book with such subsidiary cash books, as may be necessary in any particular case (*All Offices*).

(*b*) A Minute book showing the payments authorized by the office (*All offices*).

(*c*) An inventory of the property of the Office not being moneys or securities (*All offices*).

(*d*) Register of instruments, agreements and contracts entered into by or on behalf of the Fund (*Central and Regional Offices only*).

(*e*) A register of investments, held by the Fund, showing separately each investment made, the cost of each investment, together with a record of the nominal amount of each investment, such particulars as may be necessary to identify and the place where the scrip, security or other document of title is deposited (*Central Office only*).

(*f*) A ledger, containing the following accounts, together with such subsidiary accounts as the office may, from time to time, require :—

(*i*) Current Account with the Office (*All offices*).

(*ii*) Contingencies Account (*All offices*).

(*iii*) Administraton Account (*All offices*).

(*iv*) Reserve Funds Accounts (*Central Office only*).

(*v*) Investment Account (*All Central Offices only*).

(*vi*) Regional and Local Offices Credits Account showing the amount due from the (*Central Office only*) Central to Regional and Local Offices).

(*vii*) Central Offices Fund Account (*For Regional and Local Offices*) for amounts due from them to Central Office.

(*viii*) Benefit Fund Account (*All offices*).

(*g*) Register of sums due and paid to medical practitioners (*For Local Offices of Panel Centres only*).

(*h*) Register of sums due and paid in respect of supply of drugs, medicines and appliances (*Local Offices and Regional Offices*).

(*i*) A Membership Register with particulars necessary for identifying each member and for enabling the rates of contribution benefits applicable to him to be determined. There will be columns showing : Member's number, name, class, occupation, date of birth, date of entry into insurance, area of the local office, date and cause of going out of insurance, and particulars in case of women members (if necessary).

(*j*) A Contributions Register, with particulars necessary for identifying a member and for enabling the number of contributions and for ascertaining the number of contributions paid and to be paid (arrears) to determine the right of the insured to benefits. There will be columns showing : Member's number, name, arrears paid in the current year, contributoins of and paid in current year, number of contributions exempted, arrears due at the end of the year, number of stamped cards received during the year and the date and cause of going out of insurance.

(*k*) A Cash Benefit Register showing full particulars about cash benefit paid, etc. There will be columns showing : Member's number, name, date of birth, reference to number of membership and contribution registers, date of beginning of incapacity, duraton of previous incapacity for "linking-up" purposes, rate of cash benefit. Particulars for any change in the rate because of arrears, linking-up, etc. should be filled in immediately on the first notice of incapacity being received. Columns recording actual (daily) cash benefits should be written up week by week as soon as payments are made, while columns showing nature of incapacity (from medical certificates), duration of incapacity, total cash benefit paid, total duration of incapacity in the year (after linking-up) and any remarks should be filled up as soon as the member "declares off". In this register, the totals of cash benefits taken every week should agree with the corresponding totals in the cash book (*Local offices only*).

(l) A Maternity Benefit Register (if this benefit is provided) to record payments of maternity benefit to insured women workers (*Local offices only*).

In conclusion, it may be stated that specimens of Cards and Registers have been obtained from the Ministry of Health and are retained in the Labour Department. Three Cards (in an adapted form) are, however, reproduced here for information and general indication. The Register forms are too large to be reproduced.

YEAR 1945. | *FRONT* | I. CONTRIBUTION CARD. | REGION

NATIONAL HEALTH INSURANCE : INDIA.

Name of Centre..... No. in Centre.....
Name in (Block Letters)..... (Surname first).
Address .....
Occupation.....
Date of Entry into Insurance.....

January. 1 1945	February. 2 1945	March. 3 1945	April. 4 1945	May. 5 1945	June. 6 1945
		Monthly Rate of Contribution Employer .. Rs. / Worker .. Re. } Rs. 1/8. (See overleaf).			
July. 7 1945	August 8 1945	September 9 1945	October. 10 1945	November. 11 1945	December. 12 1945

NOTICE TO EMPLOYER	Each stamp should be very firmly affixed and the date of affixing it at once written in ink (or stamped with metallic die) across face of stamp.

Signature (or thumb impression).....

Change of Address.....
(New address to be notified to Centre within 7 days.)

IMPORTANT

*USE ONLY HEALTH INSURANCE STAMPS.

*DO NOT STAMP CARD DURING SICKNESS OR UNEMPLOYMENT.

WARNING.—ANY PERSON WHO REMOVES A STAMP FROM THIS CARD OR MAKES USE OF A STAMP SO REMOVED IS LIABLE TO PROSECUTION.

NATIONAL HEALTH INSURANCE.

BACK

1945

Seal of Mark of NATIONAL HEALTH INSURANCE INDIA.

CONTRIBUTION CARD.

INSTRUCTIONS TO INSURED PERSON.

This card must be delivered to your employer at the proper times for stamping.

The Card must be surrendered to the Local Office of your Centre, with your Record Card, immediately after 1st January 1946 and not later than 15th January 1946.

Failure to surrender the Card promptly may result in serious loss of benefits.

If the card is unstamped or partly stamped, you should state the reasons.

INSTRUCTIONS TO EMPLOYERS

The Contribution is payable for each month during the whole or any part of which the insured person is employed.

The Card must be stamped not later than the time at which wages are paid.

The Card must be returned to the insured person duly stamped:

(i) When the employment ends or within 14 days if he leaves without notice.

(ii) Within 48 hours after request by the worker at any time.

Each stamp must be cancelled in accordance with the notice overleaf.

At the end of the currency the card must be returned to the worker not later than.....

Class.	Rate of wages.	Employer.	Worker.	Total.
		Rs. A. P.	Rs. A. P.	
A	Over Re. 1 a day	1 4 0	0 12 0	Rs. 1/8.
B	Over 8 as. but less than Re. 1	1 4 0	0 8 0	
C	Less than 8 as. a day.	1 4 0	0 4 0	

A PERSON FINDING A LOST CARD SHOULD DROP IT INTO A POST OFFICE LETTER BOX.

1945. *FRONT*

II BENEFITS RECORD CARD.

• SEAL OR MARK.

NATIONAL HEALTH INSURANCE, INDIA.

Name of Centre:.....

No. in Centre.....

Members' Name and Address .....

.....

Occupation.....

Reference to Contribution Register .....

SICKNESS (CASH) BENEFIT RECORD

Nature of Illness	Ref. No. of Benefits Register.	Date of Incapacity		Duration of Benefit paid or deemed to be paid.	Remarks.
		Began.	Ended.		

BACK

REFERENCE TO H. I. MEDICAL OFFICERS.

Date of Reference.	Examination Particulars.		Remarks. (Doctor : Duration of Med. treatment).
	Date.	Result.	

MATERNITY BENEFIT RECORD.

Date of		Date of		Date of	
Confinement.	Payment.	Confinement	Payment.	Confinement.	Payment.

ADDITIONAL NON-CASH BENEFITS RECORD.

No. and Nature of Benefit.	Date of Payment.	No. and Nature of benefit.	Date of Payment.

INSTRUCTIONS TO THE INSURED WORKER :

Signature or thumb impression .....
Any change of address .....
.....
.....

III. RECORD OF CONTRIBUTION (CLASS C).

Contribution per month Re. 1-8-0.		Contribution year—1944-45. Benefit Year—1945		Contribution year 1945-46. Benefit Year—1946		Contribution Year 1946-47. Benefit Year—1947		Contribution Year 1947-48. Benefit Year—1948	
		No. of Contributions.	Initial of Official	No. of Contributions.	Initial of Officials.	No. of Contributions.	Initial of Official	No. of Contributions.	Initial of Official.
Contributions Paid	July to Dec.	II / 44		II / 45		II / 46		II / 44	
	Jan. to June.	I / 45		I / 46		I / 47		I / 48	
Contributions excused (notified sickness and proved employment).									
Total Credited ..									
Arrears Due ..		@Re. 1-8		@Re. 1-8		@ Re. 1-8		@Re. 1-8	
Arrears Paid ..		@Re. 1-8		@Re 1-8		@ Re. 1-8		@Re. 1-8	
Remarks.									

APPENDIX XV.—A NOTE ON THE CHOICE OF FINANCIAL SYSTEM.

[In this Note I would like to state my reasons somewhat more fully than was possible in the Text for the adoption of the Budgetary System as the basis of the financial structure of the Scheme. The arguments put forward are not my own but of those who have had practical experience of Social Insurance in foreign countries and who have made it available to readers through the laudable enterprise of the International Labour Office. The I. L. O. Social Insurance Series (M) is the most helpful documentary evidence on all matters relating to Social Insurance that one can get concentrated in one place, although monographs by individual writers on particular countries and several official and semi-official Reports are also worth referring to.]

1. The first important argument in favour of the budgetary system is the want of relevant statistics, which puts the application of the capitalization system out of the question. It is an admitted fact that the capitalisation system can be applied only if all the statistical data of a reliable nature are available for the making of the various calculations which are absolutely essential as was the case in Great Britain in 1911 when the National Health Insurance Scheme was drafted. In the absence of such data it would be impossible to adopt such a system. In our country there are hardly any reliable statistics regarding sickness incidence, wages, age of working population, time and age of workers' entry into and exit from industry and so forth. In such a case the only system that can be applied is the budgetary system which requires no complex statistical data and calculations and which can be safely followed on certain reliable and intelligent assumptions. No actuary can, under the circumstances, frame an accurate scheme on the actuarial basis; he would be found to make "intelligent guesses", which would make the scheme more uncertain than the budgetary system which involves no complicated calculations.

2. Even if statistics were available, it would be imprudent to adopt the capitalisation system for technical reasons. The nature of the risk and other attendant conditions are such as to render the assessment system suitable to Health Insurance in a very special sense. According to the International Labour Office (*vide General Problems of Social Insurance*, p. 89), where compensation for risks represents an average expenditure which does not vary from year to year for each person insured and in respect of which the insured from the moment of first insuring acquires the right to benefits, if needed, such risks will best be met by a system of " distribution " modified by the constitution of reserve funds. It would thus seem that Health Insurance should best be organized on the budgetary plan. According to the same authority, the capitalization system is suited only to those risks in which the average expenditure in respect of each insured person is liable to vary very considerably every year, or when the right of an insured person to the receipt of benefits is deferred in relation to the date of his entry into insurance, or, lastly, when the benefit takes the form of periodical instalments paid to the party entitled thereto, payments which will probably cover a fairly long period. None of these features are found in Health Insurance; and it would seem that purely technical reasons make capitalisation unsuitable to Health Insurance.

3. There is yet one more reason why the capitalization system cannot be adopted in this country. This system may be, to some extent, suitable to those countries which have a permanent industrial proletarian class and where the ages of entry into and exit from the industry can be definitely fixed, *e.g.*, at 18 years and 60 years. But in India, where workers join the industry and also make their exit at every conceivable age, difficulty would arise from workers joining at a later stage of their age, for they would then be contributing less and demanding more. This would upset every year's calculations. It is true that some young persons would be leaving the industry before they withdraw any part of the Fund they have contribted; and that this would make up for the gap caused by the entry of some persons at later stages. But there is no warrant for this view, *i.e.*, for supporting that this sort of equilibrium would thus be established.

4. Moreover, it cannot be said that the capitalization system is in any way better than the budgetary system. As a matter of fact the two systems do not ultimately differ from each other so far as the consequence is concerned. The differences between them all emanate from one basic difference, *viz.*, the mode of grouping. Under the budgetary system it is each year's group which is taken into account. Every year a group is formed and at the end of the year, this group is dissolved. The character of any one year's group generally remains the same as that of any other year's group, unless the intervening time is very long. In case there is any new development in this intervening period, one year's experience can be used in the next year to take this into account. In the case of the capitalisation system, the grouping is a historical one. Every year, it may be said, a new group is formed and it is dissolved only when the last member of the group goes out of the insurance scheme. It is because of this feature that a fund is formed which is available for investment and that a fund value in respect of an individual insured person can be calculated. There is nothing to show here that one system is superior to the other. As the I.L.O. rightly observes, " the choice between the two systems is simply a matter of expediency ". (*Vide, General Problems of Social Insurance*, p. 78). In principle, both would work equally efficiently; and in practice, the Budgetary System would be found to be much more simple and intelligible than the other.

5. Simplicity, then, is an additional argument in favour of the Budgetary System. It is an admitted fact that the Budgetary System is simpler to frame, equally simple and certain in operation, and more easy for administrative purposes. The capitalization system involves a lot of calculation and assumptions which have often been found to fail to bear out in practice, to be difficult and uncertain in operation, and too intricate for administrative purposes. If both the systems are taken to yield equally good results, even then there is much to be said in favour of the system which is much simpler, in every important respect, of the two.

6. It is because of reasons like this that all the world over it is the Budgetary System which has been adopted in sickness insurance schemes. Great Britain and Ireland are the only countries which have adopted the capitalization system but they had to do it because it was essential to continue and maintain this feature while converting the existing sickness insurance schemes from voluntary to compulsory basis in 1911. India should not be made to follow blindly the example of one country and to ignore the practice of practically every country in the world where things could be done rationally. What Britain had to adopt under compulsion and what she would have fain avoided otherwise, must not be adopted by choice in India!

7. The Budgetary System has this additional advantage that it provides an effective and regular check on the various assumptions made, inasmuch as any particular year's experience forms the guide for the next year. Under this system as the total resources are made equal to total charges regularly and year after year, the obvious conclusion is that it affords guarantee that the scheme will at any time be able to meet its financial obligations. (See Lucien Féraud, *Actuarial Technique and Financial Organization of Social Insurance, p. 32*).

8. By token of the same reasoning, it is best suited for taking into account all the current changes in relevant economic spheres which are going on from time to time and for providing for them in an automatic manner.

9. One great argument against the adoption of the capitalization system is that it lacks flexibility. According to the I. L. O., "The system of capitalization lacks flexibility, compared with that of distribution (budgetary). Any alteration in the law, which changes the respective obligations of the parties during the course of the contract between them, reacts on the practically unlimited series of future financial years which are all interlocked" (*vide Compulsory Sickness Insurance*, p. 466). Since a guiding principle of this Sickness Insurance Scheme is flexibility, the capitalization system which would sabotage this principle cannot be obviously adopted.

10. Moreover, the system of capitalizaton can at best make actuarial provision for the cash benefit to be granted, this being a more or less definite quantity, measurable as a rate per insured worker, and its future incidence being predictable with a fair degree of accuracy. But apart from the cash benefit, there are two equally important elements of costs, *viz.*, the costs of medical benefit and the costs of administration. If the panel system of medical administration is adopted and payment is made on the basis of the number of insured workers on the list of each panel doctor, the problem of medical costs, is to some extent simplified. But the modern trend of medical administration is more in favour of socialized medicine and group practice, which make for both efficiency and economical management, and, as this is the pattern which is recommended, on various grounds (See Chapter VI), for India. I do not think the system of capitalization has any special application here. The same is true of the costs of administration. Here also the capitalization system and the budgetary system will have to make practically the same assumptions. As the costs of cash benefit are likely to correspond to no more than 30 or 40 per cent. of the total costs, it is clear that the capitalization system has no special claims to being considered as more reliable or more accurate than the other.

11. Capitalization is a long-term financial operation; and would consequently require frequent re-examination of sickness statistics and experience, valuation of assets and liabilities and so forth, as a consequence of changes in the rates of interest and morbidity. And it must be remembered that moribidity is less known and less stable than mortality; while no one can guarantee the stability of interest rates, especially after the war. Such revisions would lead to changes in the financial system, and constantly frustrate expectations.

12. It has been found in actual practice, (*e.g.*, in United Kingdom) that when the capitalization system is applied to Health Insurance, it leads to uncertainty regarding the extent of benefit, adequacy or otherwise of resources, adequacy or otherwise of contributions and so forth. The Scheme has to be readjusted in the light of every fresh valuation. This sort of constant uncertainty and change is highly objectionable and results from the wrong application of the system of capitalization to a sphere where the risk is so unstable and unknown.

13. The position of the Government of India with regard to this point seems to be definitely opposed to the capitalization system. The idea that an actuarial examination should precede the framing of the Scheme has been definitely discarded by them for the obvious reason that there is an absolute want of statistics forbidding the holding of any full-fledged actuarial enquiry at the present stage, and that in order to make such an actuarial examination possible, there must be statistics which, if they are to be reliable, can be collected only when a tentative scheme of sickness insurance is actually put into operation. It is with a view to collecting statistics, on the basis of which an actuarial examination can be later had with any degree of profit and advantage, that this Scheme is being prepared. To talk of a full-dressed actuarial examination (which the capitalization method must involve) at this stage is, therefore, to put the cart before the horse.

14. The provision of a Government gaurantee further strengthens the case for the adoption of the Budgetary System. Under the Capitalization System, everything is so pre-ordained that the yearly surpluses and deficits are a matter of little worry, as it is felt that in the end things must straighten themselves out, In the meantime the Fund is merely called upon to give "credits" to administrative units on the basis of what are called "reserve values" *on a pre-conceived plan*. Hence there is no question of Government gurantee here, for the budget is not annual but almost permanent. But provision of Guarantee further helps the adoption of the Budgetary System, if its absence were any objection to the adoption of this system.

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APPENDIX XVI.—Distribution of Costs of Health Insurance in certain Countries

TABLE 40.—(*Computed from the statistics complied from the* International Social Survey, *Volumes I & II, I. L. O., Geneva, 1936*).

Country.	Year.	Cash Benefit.	Medical Benefit.	Administration.	Miscellaneous.
		%	%	%	%
Austria	1933	29·5	50·8	14·7	5·0
Czechoslovakia	1933	33·7	39·5	21·6	5·2
Denmark *	1934	14·7	66·6	11·9	6·8
Estonia	1933	26·1	63·5	7·9	2·5
Finland *	1932	47·2	37·5	7·2	8·1
Great Britain & N. Ireland	1933	50·8	27·5	15·1	6·6
Hungary	1933	28·7	42·4	28·9	†
Irish Free State	1933	70·2	7·0	16·1	6·7
Italy	1933	56·2	23·9	11·1	8·8
Japan	1932-33	32·1	54·7	8·9	4·3
Latvia ‡	1933	43·0	40·3	10·6	6·1
Luxemburg	1931	20·7	50·9	2·9	25·5
Norway	1933	25·7	65·7	8·1	0·5
Poland	1933	10·3	52·8	10·1	26·8
Sweden *	1932	85·8	2·5	9·6	2·1
Switzerland	1933	34·1	55·5	8·9	1·5
Average ..		38·5	42·2	12·1	7·2

* Scheme is voluntary.
† Not known ; included under " Administration ".
‡ Figures relate to the scheme as applicable to industrial workers only.

NOTES.—(*i*) Full information regarding the distribution of costs in Germany and Netherlands is not available. The percentage expenditure on administration in Germany is 10·8 and in Netherlands 23·4.

(*ii*) Information regarding countries having sickness insurance as a part of a wider social insurance scheme has been excluded for lack of availability of comparative figures.

(*iii*) The distribution of costs over various heads varies considerably. Distribution over cash and medical benefits varies because of the varying emphasis laid on them in different countries. Thus the percentage of sums on cash benefit to total expenditure is highest in Sweden because in this country cash benefit is all that is given to the insured persons, medical benefit being available only as an optional benefit. The Irish Free State is second in order, spending 70·2% on cash benefit and 7·0% on medical benefit, and in this country there is hardly any provision for any type of benefit in kind. As against this, Denmark spends as much as 66·6% on medical benefit (and only 14·7% on cash benefit), for here the medical benefit is of a very elaborate and comprehensive type. Medical benefit treatment medical attendance by midwife, hospital treatment, treatment in sanatorium for tuberculosis and mental hospitals; 3/4ths of the cost of insulin for patients suffering from diabetes and of liver preparations for patients suffering from pernicious anæmia ; treatment by specialists, in other curative institutions, home nursing dental treatment, massage and medical baths ; refund of cost of medicines and 2/3rds of the cost of dressing, artificial limbs, spectacles , etc. Cash benefits, on the other hand, include only sickness benefit and maternity benefit. Norway spends 65·7% on medical benefits which include all medical assistance including extraction of teeth by a dentist, physical treatment, travelling expenses of doctor, free medicines in case of accidents covered by the Workmen's Compensation Act for the first ten days, treatment and maintenance in public hospitals and in case of confinement, attendance by a midwife.

(*iv*) Cost of administration seems to vary according to the number of funds and the complexity and number of managerial bodies. Thus Czechoslovakia is the country which spends most on administration (21·6%), perhaps because it has 293 funds and an elaborate structure of several managerial bodies. On the other hand, Luxemburg spends the least, only 2·9%, on administration and here there are only a few district and establishment funds, whereas there are only one or two managerial bodies of a simple type.

APPENDIX XVII.—The Bombay Labour Office Enquiry into Sickness Incidence.

At the instance of the Royal Commission on Indian Labour, the Labour Office, Bombay, conducted in the year 1930 an enquiry into the incidence of sickness among cotton mill operatives in Bombay City. The enquiry related to three mills and covered a period of three months. The results of the enquiry (published in the *Labour Gazette*, February 1931) were not very satisfactory, as the period chosen was too short. It was, therefore, decided to take up another enquiry on the same lines to cover the same mills for a period of twelve months. The methods followed being identical in the two enquiries; we shall summarise here the results of the latter enquiry (cf. *Labour Gazette*, March 1933, pp. 517—26).

Method and scope of the enquiry.—A lady investigator was posted to each of the three mills. She visited the mill on all working days and made a list of all such persons as were absent for three days or more in succession. She then interviewed the persons on their return to work. The period covered was from December 1930 to the end of November 1931 in the case of two mills, and from December 1930 to

the end of September 1931 in the case of the third. "The main limitation of the enquiry," in the words of the *Labour Gazette*, " is that it may have failed to include sick workers who had left for their native places or had failed to return to work in the same mill, sick workers who had absented themselves without leave and had, therefore, been discharged, or, in a limited number of cases, in which a sick worker on his return was given a new ticket number or was transferred to some other department. Such cases, however, could not have been large in number and special endeavours were made by the investigators to trace every worker who had returned to work."

Features and Defects.—Apart from the various limitations of the two enquiries mentioned in the *Labour Gazette* reports, the following defects may be noted : (*i*) The enquiries related to only persons who had been absent for three days or more. (*ii*) Absenteeism on account of reasons other than sickness could not have been kept distinct from absenteeism due to sickness. (*iii*) Many workers, especially spinners, are discharged in the mills concerned, if they absent themselves for more than three-days. Hence probably many cases were not fully reported. (*iv*) In order to find out the average rate of sickness all that was necessary was to note the total number of workers in a factory and the total number of man-days lost due to sickness during the period, whether the sickness was of less than three days' duration or more. This was not done. (*v*) Sundays and holidays were excluded from the enquiries. (*vi*) The enquiries related to only three mills, which could not be regarded as good samples of the textile industry. (*vii*) The final average figure of 1·03 in the case of the first enquiry and of 1·39 in the case of the second enquiry was wrongly called "incidence of sickness". These were really percentages arrived at by dividing the total possible man-days by the total of man-days lost due to sickness of more than three days. If a reference is made to standard works on the subject (such as *Compulsory Sickness Insurance*, pp. 437—445), it will be seen that this is not the procedure for calculating morbidity rates. The table on p. 520 of the *Labour Gazette*, March 1933, showing the incidence of sickness is a hotch-potch. In the case of two mills, the enquiry was for the period from December 1930 to the end of November 1931, while in the case of the third mill, it covered the period from December 1930 to the end of September 1931. The Bombay Labour Enquiry Committee probably made correction for this fact and obtained the figure of 53,850 days as the number of days lost due to sickness of more than three days, and an average of 4·6 days (vide *Report*, pp. 328—29). The Committee also loaded this rate for the " moral hazard ", which arises when sickness benefit is payable, and brought it up to 9 days.

The following tables summarise the results of the enquiry :—

TABLE 41.—*Incidence of Sickness.*

Mills.	Average daily number of hands employed.	Total number of working days covered during the period of enquiry.	Total number of possible "Man-days" column (2) × column (3).	Number of "Man-days" lost due to workers' absence on account of sickness.	Percentage of column (5) to column (4).
(1)	(2)	(3)	(4)	(5)	(6)
Mill A*	3,692	258	952,531	11,439·5	1·20
Mill B	3,484	306	1,066,104	14,702·5	1·38
Mill C	4,568	303	1,384,104	21,219·5	1·53
Total ..	11,744	..	3,402,744	47,361·5	1·39

* Enquiry in this mill was closed from 1st October 1931.

TABLE 42.—*Medical Treatment received by Workers during Sickness.*

Kind of treatment.	Males.		Females.		Total No. of cases.	Percentage to total.
	No. of cases.	Percentages.	No. of cases.	Percentages.		
No. treatment	870	18·80	347	34·77	1,217	21·63
Country medicines	1,848	39·92	401	40·18	2,249	39·97
Western medicines	1,536	33·18	195	19·54	1,731	30·76
Country and western medicines	44	0·95	3	0·30	47	0·84
Patent medicines	294	6·35	46	4·61	340	6·04
Patent and Western medicines	7	0·15	..	..	7	0·12
Patent and country medicines ..	4	0·09	..	..	4	0·07
Patent, country and Western medicines.	1	0·02	..	..	1	0·02
Other remedies including imperfectly specified.	25	0·54	6	0·60	31	0·55
Total ..	4,629	100·00	998	100·00	5,627	100·00

TABLE 43.—*Nature of Illness.*

Nature of illness.	Males.		Females.		Total No. of cases.	Percentage to total.
	No. of cases.	Percentages.	No. of cases.	Percentages.		
Malarial fever	646	13·96	87	8·72	733	13·03
Other fevers (unspecified) ..	1,740	37·59	430	43·09	2,170	38·56
Diarrhoea.	226	4·88	39	3·91	265	4·71
Dysentery.	126	2·72	20	2·00	146	2·60
Stomach complaints	337	7·28	122	12·22	459	8·16
Headache or cold	213	4·60	37	3·71	250	4·44
Skin diseases	283	6·11	32	3·21	315	5·60
Injuries caused by accidents in mill.	168	3·63	12	1·20	180	3·20
Other injuries	135	2·92	30	3·00	165	2·92
Pain in chest, waist, leg, etc. ..	218	4·71	41	4·11	259	4·60
Diseases affecting teeth, ears and eyes.	120	2·59	32	3·21	152	2·70
Respiratory diseases	131	2·83	28	2·80	159	2·83
Others*	278	6·01	88	8·82	366	6·50
Imperfectly specified	8	0·17	..	..	8	0·14
Total ..	4,629	100·00	998	100·00	5,627	100·00

TABLE 44. *Number of Cases of Sickness according to Age.*

Age groups.	Number of cases of sickness.				Age distribution of cotton mill workers in Bombay City.
	Males.	Females.	Total.	Percentage to total.	
(1)	(2)	(3)	(4)	(5)	(6)
Below 15 years	..	..	..	..	0·22
15 years to 20 years	292	73	365	6·49	10·61
20 years to 25 years	813	287	1,100	19·55	22·26
25 years to 30 years	1,348	278	1,626	28·90	22·26
30 years to 35 years	861	134	995	17·68	16·69
35 years to 40 years	607	101	708	12·58	10·68
40 years to 45 years	334	68	402	7·14	8·75
45 years to 50 years	189	33	222	3·95	3·56
50 years and over	185	24	209	3·71	4·97
All ages	4,629	998	5,627	100·00	100·00
No. of cases of sickness per hundred employers.	46·37	56·67	47·91	..	..

*Include cases of " Swellings " ; " Chicken Pox " ; " Sprains " ; " Mumps " " Rheumatism " ; " Piles " ; " Nausea " ; etc.

APPENDIX XVIII.—Existing Medical and Sick Pay Facilities Provided by Employers.

The case of private employers, providing either sick leave or medical benefit or both, and of those who might have adopted regular health insurance schemes was carefully considered by me. It may be recalled that at the Ministerial Labour Conference s (vide *Proceedings*) suggestions were made by official representatives from some Provinces that the existing medical facilities should be preserved as far as possible and the " good work " done by employers by way of provision of hospitals etc. should not be undermined. There are many factories which actually provide, though in varying degrees, medical benefits and sick-pay facilities of some kind or other. It becomes, therefore, extremely difficult to draw the line in this connection, and the fear may be expressed that if some employers are permitted to continue their " good work," it may easily be the thin end of the wedge, which may ultimately frustrate the idea of health insurance altogether. On the other hand, I am convinced that there is a case for the protection and preservation of at least some of the schemes of medical benefits which are in operation at present. The existing medical facilities in most places are no doubt extremely inadequate ; even some of the so-called health insurance schemes are a mere parody of what they should be. There is hardly any case for their continuation but in some very few places the facilities may appear to be not much inferior or even in fact initially superior to those proposed in this Report. In their written and oral evidence some employers have insisted that, if possible, a *via media* might be found so as to continue some of these facilities. Although, generally speaking, workers have been inclined to regard the facilities provided by employers as inadequate and even farcical, in some, extremely few, instances they have showed an inclination to agree to the continuation of really first-class facilities.

In none of the discussions which I had with employers and workers, however, was any concrete suggestion made by anybody indicating the way in which such first-class facilities might be continued without endangering the scheme. Some vague proposals were no doubt made suggesting absorption of the existing facilities. At a later stage, therefore, I issued a Special questionnaire (*vide* Appendix IV) with a view to eliciting the views of some select organizations which had already replied to the other questionnaires. Unfortunately, most of the organizations, baring one or two, have given only superficial answers, such as that facilities are quite adequate, or that nothing further need be done about them, etc. I have, therefore, to fall back mainly on my own observations and impressions in this connection. Before tackling the issue of continuance of these facilities, certain preliminary questions may be considered. In the first place, what are the principal motives of employers in maintaining these facilities and are these motives likely to continue even after the inauguration of the scheme ? Secondly, what is the standard of the medical facilities provided, and are they in any case likely to be either equal or superior to the facilities proposed under the present scheme ? In regard to the first question in the course of my conversations with workers' and employers' representatives, various motives were suggested. I do not propose to verify the reality of their existence or otherwise, but I may simply state them here. Provision of first-aid appliances was no doubt the basic minimum prescribed by the Factories Act, Sec. 32 (*b*), and rules thereunder made by the Provincial Governments, but in other cases the most charitable construction put upon the employers' facilities was that they were a concession t o public opinion " an implicit answer to the more inconvenient reproaches of workers," as a philanthropic activity, and finally, as the result of a genuine desire on the part of employers to improve the physical efficiency of their employees. Less charitable motives suggested were the desire to obviate losses from absenteeism, the provision of cheap and free medical aid to the high-paid officers and families and relatives of employers, employment of friends and relatives of employers in the capacity of medical officers on substantial salaries (especially in the case of joint stock companies controlled by Managing Agents), and finally, protection of employers' interests in respect of the Workmen's Compensation Act. It is obvious that after the inauguration of the scheme the former set of motives is likely to weaken, but there is no reason to suppose that the latter set of motives will be revised. In all probability, therefore, it may happen that the employers will decide to continue some of these facilities, and in any case, the low-paid worker may be largely prevented from enjoying the full measure of the facilities. On the whole, employers are bound to contend that there is no reason why they should continue to maintain facilities and incur double expenditure on account of these benefits. As regards the second question, *viz.*, the standard of these medical facilities, it is clear that the range is very wide indeed ; from first-aid appliances and small dispensaries to first-class hospitals and clinics there is a gradation of medical benefits provided by the employers. But medical benefit is not linked fully to cash benefit or sick pay in every case and while in some cases medical benefit may appear to be better than that proposed under the present scheme, the cash benefit may be inferior, and *vice versa*. It is, therefore, difficult to draw a clear line of demarcation indicating the comparative position. Obviously, if some of the proposals suggested later are adopted, the Central Board will have to decide in a practical manner as to which of the concerns in the industries subject to insurance have been providing medical and sick pay facilities " not on the whole less favourable than " the benefits suggested under the scheme. In other words, it is mainly a question of fact. From my personal investigation, (*vide* Appendix VI and notes under Tables), I can say that such concerns will be very few indeed, perhaps not more than a dozen or so.

We may now turn to the various solutions which can possibly be suggested for bringing the private employers' facilities into harmony with the scheme. Four alternative solutions may be considered : (1) to permit the present system to continue but to allow the employer's doctor to certify sickness and treat the workers, compensation being granted to the employers for the medical expenses on an agreed basis, (2) to take over the existing facilities, including the staff and equipment, making them completely

amenable to the Fund's control, (3) to ignore the private employers' facilities altogether, leaving him to decide their future as he thinks fit, and (4) to extend, in a *selective* manner, the same privileges as are to be granted to Government concerns, under the heading " Scheduled Exceptions," to such private concerns as may satisfy certain special conditions laid down for this purpose. Let us consider these alternative solutions *seriatim*.

The first alternative is obviously undesirable. The very essence of health insurance is that cash benefit and medical benefit go together, the connecting link being certification, and that certification has to be fully controlled and beyond the pale of even the possibility of fraud. For this reason, it is necessary, as emphasized elsewhere, that the doctors should be fully under the control of the Fund; otherwise, divided control will mean divided responsibility and leakage of funds will ensue. It is impossible to accept the view that the employer's doctor will have the interest of the Fund at his heart or that the employer will be employing his time in seeing that false certification and collusion between the worker and doctor does not take place. It is to be feared that some of the worst features of the panel system will be repeated here with disastrous consequences. This course, therefore, must be rejected as wholly impracticable.

The second course mentioned above, however, has much to commend itself but there are several difficulties in the way. In the first place, the employers appear to be unwilling to hand over their medical establishments to the Fund, primarily because such establishment are subservient to their own interest, as we have noticed elsewhere. Secondly, some of the employers pay very fat salaries to doctors (who in some cases, are their own relatives or friends). The Fund cannot agree to pay salaries on the same scale to doctors, and that is another reason why employers are not likely to agree to part with their own arrangements. Thirdly, the dispensaries or first-aid rooms, are practically in every case inside the factories, and there are several reasons why the Fund's doctors should not work inside the factories. All things considered, however, this alternative is superior to the first, and if some of the difficulties mentioned above could be overcome, it could be adopted in the future. However, in this respect it might be best to hasten slowly.

The third alternative may be too drastic and indiscriminate and must be ruled out as such. It is the fourth alternative, however, which requires careful consideration. The case for exception from the scope of the Act of a limited number of industrial concerns on the ground that the facilities provided by them are either equal or superior to those prescribed under the Act is no doubt theoretically strong. There are, however, great practical difficulties in permitting such exceptions in such a manner that they do not open the way to fraudulent evasion and frustration of the Act. The main ground on which a limited measure of exception can be given is that the Fund itself may not be in a position, especially in the initial stages, to build hospitals or to purchase high-class medical equipment, and that it would be wasteful to force the factories concerned to close down useful amenities. On the other hand, it is obvious, that the legal exception, to be effective in its purpose, must be hedged in with a sufficient number of checks and balances. The following concrete suggestions may be made in regard to the conditions which must be satisfied if exception under the Act is desired by an employer: (1) The employer must make a written application to the Central Board, asking for an exception under the Act and stating reasons therefor along with particulars regarding the medical facilities and sickness benefits provided by him, either independently or under a scheme to which he and his workers are joint contributors. (2) There must be a registered agreement between the workers concerned and the employer accepting the arrangement, the workers' side being represented by a recognised Trade Union, wherever one exists, or by *ad hoc* representatives of the workers specially elected for the purpose under the Act. Such an agreement will be subject to revocation on either side after one year's notice, which must be conveyed to the competent authority. But denouncement of such an agreement or a threat of such denouncement must not be used as a counter in any strike or lock-out negotiations. Further, if the Central Board is satisfied that consent by workers is frivolously withheld, it may waive this condition. (3) The competent authority, after having received the application and agreement must also satisfy itself (*a*) that the agreement was arrived at genuinely between the two parties, and that the workers were represented by duly elected representatives or by a recognised Trade Union, and (*b*) that medical facilities and sickness benefits mentioned in the application and the agreement are in fact provided and are not inferior to those prescribed under the Act. (4) Any concerns which have obtained such exception should make immediate arrangements to constitute a Committee of Supervision on which there should be representatives of workers, the employers and the Fund in equal number, the Local Officer being the Chairman, and which would be entrusted with the task of enforcing the agreement and the benefits and facilities contained therein, making regular reports to the competent authority. (5) This part of the provisions of the Act should be given a time limit of 5 years, after which, in the light of experience gained, both in regard to the general scheme and to the employers' facilities as excepted under the Act, they should be duly revised or discontinued. (6) It will be one of the functions of the Medical Supervisors to visit the " excepted " concerns with a view to gathering first-hand information about the working of the Provisions of the Act and to report to the competent authority. (7) Finally, detailed regulations will have to be laid down under the Act to cover this subject.

It may be noted that in the United Kingdom, under the Workmen's Compensation Act, the employer can avoid liability if he satisfied the Registrar of Friendly Societies that he has a scheme of compensation in operation which provides scales of benefit not less favourable than those to which the workers would be entitled under the Act, and also that a majority (to be ascertained by ballot) of the workers are in favour of such a scheme. The same procedure may be adopted here, with numerous additional safeguards as suggested above. It may be contended by the employers that the workers' consent to

an agreement for contracting out of the Act will be difficult to be obtained, in view of the fact that it is the employer who would be more anxious than the workers to preserve the facilities. This contention would be justified if the workers are inclined to think that the facilities provided under the Act are better than those provided by the employer. It may even be conceded that workers may in some cases be cussed enough to use this right to trouble the employer ; but it is difficult to imagine that any group of workers would be so blind to their own interests as to harass the employer even when his facilities are better. The provision that in exceptional cases, the competent authority might waive the condition, I think, will meet this objection. On the worker's side, the possible danger is that they might be influenced to vote in favour of agreement, even when the facilities are not up to the mark. This danger would be greatest where the organisation of labour is poor. But even if an employer secures the consent of workers illegitimately, he will have to jump over the other hurdles, *viz.* examination of the agreement, inspection of facilities and the future possibility of revocation of agreement. Furthermore, he will have to act under the surveillance of Inspectors and Medical Supervisors.

Some organisations of employers have suggested that instead of excepting concerns where facilities were of a first-class order, we might include them in the scheme, subject to the provisions, firstly, that such concerns would be periodically visited by Inspectors and Medical Supervisors for ascertaining strict compliance with standards laid down under the Act, and , secondly, that either the employer's doctor should be allowed to certify as well as treat the sick worker or the health insurance doctor should certify and the employer's doctor treat the patient. I am not in favour of these proposals and for the following reasons : In the first place, division of responsibilities for cash benefit and medical benefit would be financially disastrous. One cannot imagine that either the employer's doctor can have any special solicitude for the solvency of the health insurance funds. Moreover, under these circumstances, the other checks, such as sick visitation, supervision of the Local Committee, direct control by the authorities on the doctors etc., will not be available, unless there is duplication of the administrative machinery permitted within the four corners of the employer's scheme. The proposal, on the other hand, to separate certification from treatment makes matters even worse and ignores the fundamental principle discussed in Chapter VII, Section A. I think, therefore, that there are only two ways of dealing with superior facilities, *viz.*, either to completely absorb them within the national scheme or to keep them outside, subject to special restrictions.

Absorption can be by way of taking over, by purchase, of the existing facilities, if the employer concerned is agreeable. The exact compensation to be paid should be determined by negotiation, of, failing this, by arbitration. Generally speaking, the entire facilities, including staff equipment, appliance and medicines and buildings might be taken over. If, however, the hospital or dispensary is inside the compound of the factory, it would not be desirable to acquire the building, because in that case the independence of the medical unit will be affected even in small matters. In such a case, the staff, equipment etc., might be transferred to some other building outside the factory. A more serious difficulty is likely to arise from the fact that the medical facilities are meant not only for the workers but also for the officers, superior staff and even for the family and relatives of the employer. While transferring the facilities to the health insurance authorities, the employer might be allowed in suitable cases to stipulate that the superior staff etc. should continue to obtain treatment at the same place, subject to the provision that the employer would be called upon to make a special lump-sum annual contribution for this purpose. This facility is likely to be appreciated by the employer as also by his superior staff, particularly in remote areas, where no alternative facilities are available to them. It may be mentioned here that in many such remote areas, even for the non-industrial population , the factory dispensary is often the only resort for medical treatment. It might, therefore, even be necessary to continue the same arrangement for some time, provided the Provincial Government or local authority agrees to give adequate assistance. The fact that an employer's dispensary or hospital has thus been acquired should not, however, obviate the necessity of having first-aid facilities in any factory. The rules in this regard require to be amplified, so as to provide complete first-aid and emergency treatment in cases of acute diseases or accidents. Of course, for subsequent treatment the worker would be removed to the nearest health insurance centre.

APPENDIX XIX.—The problem of state participation in the Financing of Health Insurance.

The questions to be decided in this connection are, (*i*) whether the State normally bears financial responsibility in regard to health insurance, (*ii*) what is the position, particularly, in Federal countries, (*iii*) on what grounds can State contribution to a scheme designed for a section of population be justified, and (*iv*) what may be said to be the legitimate size of the liability of the State in connection with health insurance.

I. As regards the first question, as stated in Chapter IX, Section A, there is nowhere to be found any reasoned statement regarding the distribution of liability as between the three main parties to social insurance, *viz.*, the State, the employer and the worker. Traditionally, workmen's compensation has been regarded as the special responsibility of the employer, but even here in recent years there has been some doubt expressed. In regard to other types of social insurance, however, generally speaking, the modern trend appears to be in favour of tripartite participation. The following States have financially participated in health insurance *in some form or other*, as may be seen by reference to Appendices XX and XXI :—

Belgium, Bulgaria, Chile, Denmark, Estonia, France, Germany, Great Britain, Ireland, Hungary, Japan, Latvia, Lithuania, Luxemburg, Netherlands, Norway, Poland, Peru, Russia, Portugal, Sweden, Switzerland and Yugoslavia.

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On the other hand, the following countries have no State participation of any kind in the finances of health insurance :—

Australia, Czechoslovakia, Finland and Greece.

In the U. S. S. R., the entire burden of health insurance is borne by the industry, which is virtually owned by the State. In Australia and New Zealand, again, income security schemes have come into being as an extension of social assistance " to ever wider categories of needy persons—to the sick and unemployed, as well as to the aged, the invalid, widows and children generally." It is difficult here to analyse and attribute the financial burden of individual schemes, seeing that the entire problem of income insecurity is now being attacked *en masse*.

It must be stated, however, that the factual position as stated in Appendices XX and XXI is, to a large extent, out-of-date, and that technical opinion in recent years, mainly owing to the new movement for Social Security, is moving towards an increasing participation by the State in the finances of social insurance. Thus, to quote the Experts' Report (IV—1) on *Social Security—Principles* (Prepared for the Philadelphia Conference) :

> " The State is responsible for the residual cost of social insurance, which is not met by insured persons and employers' contributions. It has to divide with the employer whatever share of the cost cannot equitably or without hardship be imposed on the insured person ; the proportion in which that division is made may well differ according to the fiscal capacity of the State. They include the deficit of contributions of persons brought into insurance late in life, the contingent liability involved in guaranteeing basic long-term benefits, adequate maternity benefit, and, in times of heavy unemployment, unemployment benefit, and subsidies to the insurance of persons of small means. Apart from these charges, the State has of course the considerable burden of social assistance, children's allowances and health services, all of which are essential features of a social security system."

In India, moreover, health services are going to be provided under a general health programme of an all-India character in the future, while even now liability for provision of health facilities is accepted by the State already. It is, therefore, a fair proposition that the State should contribute towards the cost of the medical benefit side of the scheme to the same extent as it does or would do in the future in regard to provision of medical facilities to the general population, thus putting those who are covered by the scheme and those who are not on a footing of equality. That the Provinces, were already providing medical facilities in urban areas for those who want to use them is no argument for those facilities are utterly inadequate and probably a fraction of what the State would have to provide if the State accepts its full responsibility in this matter, and the case for a separate medical service for industrial workers, unified with the machinery for provision of cash benefit, is strong. It is no use saying that the establishment of the present scheme will not lighten the burden of the State materially, and that in any case, Government dispensries and hospitals will continue to be as crowded as before, because the relief provided to the State must be considered not in respect of the existing facilities which are admittedly poor and inadequate, but in regard to the potential facilities corresponding to the full responsibilities of the State in this regard.

II. The next question is as to what is the practice in Federal countries. This arises mainly in connection with the allocation of the liability as between the centre and Provinces (or States). The Position in the different federations may be stated briefly. In the United States, there is as yet no system of national insurance against non-occupational sickness ; nor are there any schemes of social insurance to cover risks of unemployment, old age and death of bread-winner. The Social Security Board as well as the National Resources Planning Board, therefore, have recently recommended the inclusion of these measures under the Social Security Act. They strongly favour that " a proportion of the funds should be derived from general tax revenues collected on a progressive basis." In Chile, under the Act of 1924, compulsory insurance against sickness, invalidity, old age and maternity is financed by a tripartite contribution. In the U. S. S. R., as indicated earlier, contributions are made by the State undertakings themselves and not the workers employed by them. In Australia, it is reported that a sum amounting to £30,000,000 annually, or a sum equal to one-fourth of the income-tax yield, whichever is less, is proposed to be paid into the social security fund. In South Africa, there appear to be some voluntary schemes of health insurance combined with other risks, but the Social Security Committee, who reported this year, have recommended a comprehensive (but rather complicated) programme, and have accepted that the " State will have to bear a considerable proportion of the costs " of such a programme. In Switzerland, the Conferderation grants (*a*) subsidies according to the number of insured persons, (*b*) a supplementary subsidy to sickness funds in sparsely populated areas, and (*c*) special subsidies to Cantons or Communes, when the latter pay the whole or part of the contributions for indigent insured persons. Finally, in Canada, under the recently introduced National Health Bill, the Dominion will give each Province a fixed sum for each person who comes under the Province's own health insurance law. The *per capita* rate has been tentatively set at $3·60. If the entire population of all the nine Canadian Provinces were covered (11,765,000 in 1943), the Dominion grant at this rate would, it is stated, amount to $42,354,000 per annum. This health insurance grant is to be expended for " medical, hospital, dental, nursing, and pharmaceutical services," provided under the conditions specified.

III. All this, it may be objected, may be true of schemes which cater for the entire population. But what about a scheme which is confined to a section of the population? What justification is there for a State contribution to such a scheme. Apart from arguments detailed in Chapter IX, Section A, we may consider the following points. Firstly, a State contribution is necessary because the scheme is a *compulsory* one. Sir Alfred Watson, the famous British actuary, observed as follows at the Eighth International Congress of Actuaries (*Proceedings*, Vol. V, pp. 243-14): "What part ought the State to play in financing a scheme of social insurance? I suppose that the root of any contribution from the State is to be found in the fact of compulsion. If a Government requires its subjects to insure, it should, presumably, itself be a contributor to the scheme." Secondly, we may again refer to the principle of equalisation of medical benefit, implicit in para. I above. Thirdly, due importance should be given to the view that the health of the industrial worker is exposed *to a greater extent* than that of the non-industrial population, and that consequently it is a national responsibility to safeguard him against such risks, if efficiency of production and national income are to be maintained. Fourthly, in the final analysis, the contribution of Government is a contribution of the taxpayer. If the taxpayer can be readily burdened with protective and other tariffs for bolstering up industries, the financial benefit of which goes mainly to the investing class, it is fair that a part of the taxes thus gathered by the State and a part of the profits thus earned by the investor-employer should be earmarked for the welfare of the worker. Fifthly, in the interest of stability of the insurance fund as also in the interest of co-ordination, it is necessary that Government should participate. Otherwise, Government's right to interfere in the administration of the Fund will naturally be questioned. Finally, we cannot imagine that some sort of social assistance in the case of agricultural masses, who are mainly the landless labourers, will not be found necessary and desirable side by side with health insurance for industrial workers. In any case, Government contribution here cannot wait until the latter measure is adopted.

IV. The last question, *viz.*, the exact scope and size of the State's liability is fully discussed in the text of the Report (*vide* Chapter IX, Section A). Here it may be only stated that the State's liability as recommended in this Report is a small fraction of the amounts which Governments the world over are being called upon and are prepared to spend.

APPENDIX XX.—SHARES OF CONTRIBUTIONS IN DIFFERENT COUNTRIES*

Name of the country.	Insured person	Share of contribution by Employer.	State or Public Authority.	Remarks.
(1) Austria	1/2	1/2	*Nil*	Contribution in respect of workers not receiving any cash remuneration and that of apprentices is payable by the employer alone.
(2) Bulgaria	1/3	1/3	1/3	Contributions vary according to Wage Class.
(3) Chile	1/3 (2% of wages)	1/2 (3% of wages)	1/6 (1% of wages)	Total contribution equal to 6% of insured person's wages.
(4) Czechoslovakia ..	1/2	1/2	*Nil*	For workers who have not received cash remuneration the Employers pay the full contribution.
(5) Estonia	1/2	1/2	*Nil*	Cost of medical aid is borne by employers. State meets the expenses of general supervision.
(6) France	1/2 (2% of basic wage)	1/2 (2% of basic wage)	*Nil*	
(7) Germany	2/3	1/3	*Nil*	The new legislative provision to the effect that the contribution should be equal (1/2 + 1/2) between the employer and the insured person has not yet come into force (1938).
(8) Great Britain ..	3/7 (For Men) 2/5 (For Women).	3/7 (in the case of men) 2/5 (For women).	1/7 (for men). 1/5 (for women).	
(9) Greece	1/2	1/2	*Nil.*	
(10) Hungary	1/2	1/2	2/9 of the cost of compulsory insurance is borne by the State.	
(11) Ireland	Men 1/2 Women 3/7	1/2 4/7		
(12) Japan	1/2	1/2	State Subsidy at 1/10 of the cost of Insurance.	
(13) Latvia	1/3	1/3	1/3	In addition the employer con amount equal to 2% of wages of medical benefit.
(14) Lithuania	1/2	1/2	State bears the expenses of cash benefits payable to women in childbirth.	
(15) Luxemberg	2/3	1/3	State bears half the administrative expenses of the Central Fund.	

*The above information has been collected from different sources and indicates the pre-war position.

APPENDIX XX.—SHARES OF CONTRIBUTIONS IN DIFFERENT COUNTRIES*—(*contd.*)

(16) Norway	6/9	1/9	1/9 by State. 1/9 by Local Authority.
(17) Poland	1/2	1/2	*Nil*
(18) U.S.S.R.	*Nil*	1	.. The State and the Employer are the same.
(19) Yugoslavia	1/2	1/2	The State pays an annual contribution towards the administrative expenses of the Central Worker's Insurance Institution.

APPENDIX XXI.—A CONSPECTUS OF HEALTH INSURANCE.

A.— *Voluntary Insurance.*

(a) Societies not subsidized by the State.

Country.	Method of Organisation.	Scope of System.	Sources of Income.	Benefits.
Australia	Registered Friendly Societies under State supervision.	Generally persons in good health, between the ages of 16 and 45. Some Societies have religious, local or other restrictions.	Contributions of members varying from 1*s.* to 2*s.* a week for adults. In New South Wales only, a subvention is made by the State in cases of aged persons (men over 65 and women over 60) in receipt of continuous sick pay.	(*a*) Medical attendance for insured person and family. (b) Sick pay—Maximum benefit fixed between £ 1-1*s.* and £ 3 per week. The rates actually paid are generally lower than these maximum rates. Benefits are paid during the whole period of incapacity in most Societies. (*c*) Funeral benefit varying from £ 10 to £ 200.
Canada ..	Benefit fund administered by a board of Trustees composed employers and employees' representatives under State Supervision.	Generally all classes of permanent employees are admitted.	Contributions of members on a sliding scale based on wages and ranging from 20c. to S. 1 a month.	Medical treatment is provided including in some cases supply of medicines. Cash benefit is graded according to salaries or rates of contributions—payments are as a rule restricted to 26 weeks.
Finland ..	Mutual aid Societies under State supervision.	Insurance is open to workers and salaried employees.	Contributions of members. In some instances employers also contribute.	All the Societies pay cash benefits and half of them also grant medical aid.
Holland ..	Mutual and other benefit societies. Fund administered by physicians.	According to the rules of the society.	Contributions of members ..	Medical and hospital treatment and medicines.

Country.	Method of Organisation.	Scope of System.	Sources of Income.	Benefits.
Italy ..	Mutual benefit socieites the registration of which is dependent on conditions of organisation and exempts from stamp and other duties.	According to the rules of the society	Contributions of members ..	According to the rules of the society.
South Africa ..	Friendly Societies	According to the rules of the society.	Contributions of members ..	A flat rate of cash benefit ; and medical attendance and medicament.
Spain ..	Mutual benefit societies ..	According to the rules of the society which refer mainly to sex, age and state of health. Generally the age of admission is between 16 and 40 to 45.	Contributions of members and employers.	According to the rules of the society : Medical treatment and medicaments and institutional treatment ; and daily cash benefit.
	(b) Societies subsidized by the State.			
Belgium ..	Mutual benefit societies, of which those situated in Belgium and restricted to one function must be recognised ; others may be recognised. Reinsurance funds.	According to the rules of the society.	Contributions of members and State subsidies proportional to number of insured and amount of contributions.	To obtain State subsidy, the society must grant medical benefit for at least 2 years to contributing members and their families. Cash benefits must be granted for at least 3, but not more than 6 months. The minimum daily benefits are 6 Fr. for men over 18, 4 Fr. for women over 18 and 2 Fr. for persons under 18. Members may insure against longer illnesses in invalidity Funds.
Denmark ..	Sick funds which in order to be recognised, must comply with certain conditions and be under the supervision of the Director of Sickness Funds.	Recognised societies must have a minimum membership and trade or local limitations and admit all persons between the ages of 14 and 60 years subject to certain health, property and income qualifications.	Contributions of members State contributes 2 krone per member per annum, and one-quarter of the amount expended on the sickness benefit and a further amount for chronic and incurable cases. Communes must also contribute towards chronic and incurable cases.	(*a*) Medical and hospital treatment must be provided for members and their children under 15 years of age. (*b*) Sick pay, minimum 40 ore, maximum 6 krone per day. (*c*) Maternity benefit at same rate as sick pay for 14 days.

France ..	Independent societies not entitled to subsidies ; Approved societies and establishments of public utility entitled to subsidies and certain advantages.	According to the rules of the society.	Contributions of members and employers and State subsidy proportional to expenditure on benefits not exceeding 25 fr. a day.	According to the rules of the society. Some societies have special funds for cases of long-continued sickness.
Iceland ..	Recognised sick funds	A sick fund must comprise a definite district, accept any person between 15 and 40 years of age below certain income limits and consist of at least 50 members.	Contributions of members. State subsidy, 1 krone per member per annum in a town in which a doctor resides, 1½ krone in other places.	(*a*) Medical and hopsital treatment. (*b*) Sick pay, minimum 50 ore per day, maximum two-thirds of the daily earnings of the sick-member.
New Zealand	Through approved societies. A National Provident Fund is also established which is administered by the National Provident Fund Board.	Persons resident in New Zealand between the ages 16 and 50 having an income not exceeding £300 a year.	Contributions of members and employers and subsidies from the State.	According to the rules of the society.
Sweden ..	Local sick funds and Central sick funds, all recognized by the State, and supervision of the Social Board.	A local fund must have 100 members, must admit all persons within its area between 15 and 40 years of age, subject to certain conditions of health, may provide sickness and funeral benefits only, and must not admit a member of another fund. A central fund is competent for one or more provinces. Its membership consists principally of the members of the local funds within its area.	Contributions of members. State subsidies to local funds and central funds 1·50 kr. per member per annum, 50 ore per day sick pay, half of the expenditure on medical treatment etc., up to 3 kr. per member and a maternity subsidy of 1 kr. per day. Municipal subsidies voluntarily paid by a number of communes. Some employers contribute to establishment funds.	Minimum benefits :— (*a*) Two-thirds of cost of medical attendance or hospital treatment. (*b*) Attendance of midwife or treatment in nursery home in case of childbirth. (*c*) Sickness allowance, minimum 1 kr., maximum 6 kr., per day for up to 2 years. (*d*) Maternity allowance minimum 1 kr. per day for at least 30 days.
Switzerland .. (In some Cantons Sickness Insurance is compulsory).	Registered sick funds under the supervision of the Federal office of social Insurance.	A registered fund must guarantee good management, equality of sexes and unrestricted transfer from one fund etc another.	Contributions of members. State subsidy. Special subsidies in mountainous districts. Contributions of Cantons and communes. Voluntary contributions of employers.	Minimum benefits :— (*a*) Medical attendances and medicine or sick pay of 1 franc per day for 180 days in each period of 360 days. (*b*) Maternity benefit ordinary sick benefit for 6 weeks. (*c*) Nursing benefit, 20 francs.

B.—*Compulsory Insurance.*

Country.	Method of Organisation.	Scope of System.	Sources of Income.	Benefits.
Argentine ..	1934 .. .. National Pension Fund. (only maternity).	All women employed in industrial and commercial undertakings.	Employees : 1 day's wages per 3 months. Employers contribute a sum equal to that of their employees. State subsidy equal to the contribution of employees.	(*a*) Free attendance by a doctor or midwife. (*b*) Daily allowance equal to actual wages. (maximum 200 pesos) during the legal rest period (30 days before and 45 days after confinement).
Austria ..	1888 .. .. District funds, Establishment funds, Guild funds, Association funds, Agricultural sick funds. All under State supervision.	All wage-earners and salaried employees including agricultural and home-workers, without restrictions as to amount of income.	Contribution of 6·25 per cent of wages, shared equally by employer and insured.	(*a*) Medical attendance, medicine and therapeutical appliances for at least 52 weeks. (*b*) Sick pay, 62 to 86 per cent of average daily earnings for 26 weeks at least. (*c*) Maternity benefit, sick pay for 6 weeks before and 6 weeks after confinement. (*d*) Nursing benefit, half sick pay for 12 weeks. (*e*) Funeral benefit, 50 times the average daily earnings. Insured's dependents are entitled to (*a*), (*c*), (*d*) and (*e*).
Bulgaria ..	Social Insurance Office. Local factory inspection departments. State is directly responsible for the management.	All wage-earners and salaried employees in public and private undertakings, without regard to sex, nature of employment, or rate of remuneration.	Contribution of insured range from 1·50 to 4 levas per week. Same contributions from employers and State.	(*a*) Medical attendance, medicine and hospital treatment. (*b*) Sick pay, from 12 to 30 levas per day if home treatment and 8 to 22 levas per day if hospital treatment, on the condition that the insured person has paid contributions for 8 weeks. (*c*) Maternity benefit ,medical and midwifery attendance and sick pay for 6 weeks before and 6 weeks after confinement. (*d*) Funeral benefit ; 50 times the daily basic wage.

Chile	Compulsory insurance fund with local agencies.	Every person under the age of 65 and over 12 who has no other income than his wages and whose wages do not exceed 12,000 pesos a year. Independent artisans and shopkeepers, under the same conditions.	Contributions of 6 per cent. of wages, 2 per cent. paid by insured, 3 per cent. by employer, and 1 per cent. by State (invalidity and old age pensions also are financed by these contributions).	(*a*) Medical attendance, medicine and hospital treatment for 26 weeks. (*b*) Sick pay, 100 per cent. of wages for first week, 50 per cent. for second week, and 25 per cent. thereafter until recovery. Maximum period of benefit 26 weeks. (*c*) Maternity benefit 50 per cent. of wages for 2 weeks before and after confinement, and nursing benefit of 25 per cent. of wages for not more than 8 months. (*d*) Funeral benefit, 300 pesos.
Czechoslovakia .. (*a*) workers and salaried employers.	District sick funds. Establishment sick funds. Guild sick funds.	Practically all wage-earners ..	Contributions of employees graded according to their wages. Employer contributes an equal amount to his employees.	(*a*) Medical attendance, medicine and therapeutical appliances for insured and his family. (*b*) Sick pay 66-2/3 per cent. of earnings for 52 weeks. (*c*) Maternity benefit, sick pay for 6 weeks before and 6 weeks after confinement. (*d*) Nursing benefit, half sick pay for 12 weeks. (*e*) Funeral benefit, 30 times average daily earnings, minimum 150 krone.
(*b*) Miners ..	Central benefit society ..	All persons employed in the mining industry.	Contributions of employees and employers in equal amounts, fixed according to anticipated expenditure.	Benefits similar to those provided for general workers.
Denmark ..	Special sick funds	Alien seasonal workers ..	Contributions payable wholly by employers. State subsidy, 1 krone per insured person per annum.	Medical attendance, medicine and hospital treatment up to months.

Country.	Method of Organisation.	Scope of System.	Sources of Income.	Benefits.
Estonia	Works funds and joint funds managed by representatives of insured persons.	Industrial workers in undertakings employing at least 5 persons.	Contributions of workers : 1 to 2 per cent. of wages. Contributions of employers : 1 to 2 per cent. of wages. Employer pays cost of medical attendance and medicine.	(*a*) Medical attendance in medicine. (*b*) Sick pay, one-half to thirds of daily wage for 26 weeks. (*c*) Maternity benefit from half to full wages for 2 weeks before and 4 weeks after confinement. (*d*) Dependants, benefit optional. (*e*) Funeral benefit : 20 to 30 times the daily wage.
France .. .. (*a*) Persons employed in industry and commerce and domestic service.	Departmental funds established by the public authorities. Funds established by mutual benefit societies, trade unions or groups of insured persons. Approved employers' provident funds.	Insurance is compulsory, irrespective of sex, for all persons employed in any capacity whatever, provided their total yearly remuneration does not exceed 21,000 francs. This limit is raised to 25,000 for persons who have at least one child dependent on them.	4 per cent. of the basic wage shared equally by insured persons and employers. Maximum basic wage, 36 francs a day. State subsidy covering the cost of central administration.	(*a*) Repayment of medical and pharmaceutical expenses for 6 months. (*b*) Sick pay, 50 per cent. of basic wage for 6 months. (*c*) Maternity benefit : repayment of medical and pharmaceutical expenses, and 50 per cent. of basic wage for 12 weeks. (*d*) Nursing benefit for 9 months. (*e*) Lump sum benefit at death. one-fifth of basic yearly wage. (*f*) Dependants, medical benefit.
(*b*) Agricultural workers.	Agricultural sections of departmental funds established by the public authorities. Approved mutual benefit societies having an exclusively agricultural membership. Agricultural insurance funds assimilated to mutual benefit societies.	All employed persons and share farmers in agriculture and forestry under the age of 60 whose earnings do not exceed 15,000 francs a year. This wage limit is raised by 2,000 francs for each dependant child up to an inclusive maximum of 25,000 francs a year.	Contribution not exceeding 10 francs a month shared equally between insured persons and employers. Supplement of 8 francs per insured person per month paid by the State.	Benefits fixed by rules of insurance funds. The benefits must include the right to the repayment of medical and pharmaceutical expenses and the right to a fixed rate of daily sick pay.
(Miners) ..	Mutual benefit societies as established by employers.	All workers and salaried employees on mines.	Contributions of 3·80 per cent. of wages equally shared by insured persons and employers. The contribution may temporarily be fixed at as high as 4 per cent. of wages.	Benefits fixed by societies which may also grant relief to members' families in cash and kind. At least 5 per cent. of expenditure on sick pay must be paid into the old-age insurance fund in respect of each member of such fund.

Germany ..	Local sick funds. Rural sick funds. Establishment funds. Guild funds. Miners' sick funds. Substitute funds. All under the supervision of the Imperial Insurance Bureau.	All workmen, journeymen, apprentices and servants without regard to amount of income. Officials, clerks, teachers, tutors, homeworkers, crews of ships, etc. with incomes not exceeding 3,600 marks per annum.	Contributions, not exceeding 7½ per cent. of the basic wage of each class of workers, payable two-thirds by insured persons and one-third by employers. In guild funds the contribution may be equally shared. In miners' funds three-fifths of the contribution is paid by the insured and two-fifths by the employer.	(*a*) Medical attendance, medicine, spectacles, trusses, etc. (*b*) Sickpay, one-half basic wage for 26 weeks. (*c*) Hospital treatment with half sick pay. (*d*) Maternity benefit, medical attendance and sick pay for 10 weeks and lump sum of 10 marks. (*e*) Nursing benefit, half sick pay for 12 weeks. (*f*) Funeral benefit, an amount equivalent to 20 times the daily basic wage. (*g*) Dependants receive medical attendance and, at option of fund, maternity benefit.
Holland ..	Occupational funds and funds established by labour councils.	All workers whose annual wages do not exceed 3,000 florins.	Contributions, payable in equal proportions by employers and employees.	(*a*) Sick pay, 80 per cent. of basic daily wage subject to a maximum basic wage of 8 florins, for a period not exceeding 6 months, excluding Sundays. (*b*) Maternity benefit for 6 weeks after confinement similar to sick pay.
Hungary ..	National Workmen's Insurance Fund. Establishment sick fund. District Workmen's Insurance fund. Special funds for public transport undertakings.	All workers in industries and trade, including domestic servants and home-workers, except non-manual workers earning over 3,600 pengo per annum.	Contributions of 5·14 per cent. of wage according to wage class payable in equal proportions by employers and employees. State contribution fixed from year to year to cover part of the administration expenses.	(*a*) Medical attendance, medicine, baths and therapeutical appliances for 52 weeks. (*b*) Sick pay, 50 per cent. of basic wage for 52 weeks. (*c*) Maternity benefit, midwife and sick pay for 6 weeks before and 6 weeks after confinement. (*d*) Funeral benefit, 30 times the daily basic wage. (*e*) Dependants, the same with the exception of sick pay and funeral benefit.

Country.	Method of Organisation.	Scope of System.	Source of Income.	Benefits.
Irish Free State	National Health Insurance Society "Unified Society".	All employed persons of both sexes, over 16 years and under 70 excepting those employed otherwise than by manual labour with incomes over £250 per annum.	Employee, male 4d. ; female, 3d. per week. Employer, 4d. per week. State pays two-ninths of the cost of insurance. When the remuneration of the insured does not exceed 3 Sh. a day. the employer pays the entire contribution.	(*a*) Sick pay, 15s. per week for males, 12s. for females for 26 weeks. (*b*) Disablement benefit, 7s. 6d. per week after expiration of sick pay. (*c*) Maternity benefit, £4 for insured woman, £2 for wife of insured man.
Italy	National Social Insurance Fund. Maternity branch, administered by a board of eleven persons.	All women between the ages of 15 and 50 years employed in commerce and industry.	Employee, 3 lire per annum. Employer, 4 lire per annum State subsidy, 18 lire for each case of confinement.	Maternity benefit, 300 lire.
	National Social Insurance Fund. Tuberculosis Branch.	Workmen, learners, apprentices, persons in public offices and in liberal professions, domestic servants and similar persons in private service, between the ages of 15 and 65 years. Employees with monthly income exceeding 800 lire are exempt.	Employee : 1 lire a fortnight if their daily wage does not exceed 8 lire ; 2 lire a fortnight if their daily wage exceeds 8 lire. Employers, same amount as employees.	(*a*) Admittance to homes and institutions for treatment. (*b*) Home treatment (medical attendance). (*c*) Daily benefit for dependants at the rate of 4 lire or 6 lire during the treatment.
	Sickness Insurance for Industrial Workers. Joint Sickness Insurance Funds.	All workers who are compulsory members of the fund in virtue of clause contained in the collective agreements by which they are covered.	Contributions borne equally by employees and employers. The rate is fixed in the collective agreements.	Model rules provide for benefits in kind and cash.
	Sickness Insurance for Commercial Employees. National Sickness Insurance Funds for Commercial Employees.	All commercial employees between the ages of 15 and 60 years.	Contributions of employees to cover the cost of compensation to the insured person for loss of salary ; employers' and employees contributions to cover the cost of benefits in kind. The rate is fixed by the governing body of the Fund.	(*a*) Repayment of medical and pharmaceutical expenses up to a maximum of 1,250 lire a month. (*b*) Daily allowance for a maximum of 180 days equal to the amount of the daily remuneration.

Japan ..	Health Insurance Societies or State Health Insurance Offices.	All persons working in industrial, mining or transport undertakings employing 5 or more persons. Administrative employees with annual incomes over 1,200 yen are exempt from insurance.	Employees, up to 3 per cent. of daily remuneration. Employers, same amount as employees. State, 10 per cent. of the expenditure, maximum 2 yen yearly per insured person.	(*a*) Medical or hospital treatment for 180 days. (*b*) Sick pay, 60 per cent. of daily wage for 180 days. (*c*) Maternity benefit 20 yen and sick pay. (*d*) Funeral benefit, 30 times the daily wage, minimum, 30 yen.
Latvia	Work funds. Joint funds. Trade funds.	All workers in private, communal and State undertakings who receive remuneration, except agricultural workers.	Employee, from 1 to 2 per cent. of wages. Employer and State pay the same amount as employee, and the employer also pays the cost of medical attendance (2 per cent. of wages).	(*a*) Medical attendance for 26 weeks. (*b*) Sick pay, from 60 per cent. to 90 per cent. of wages for 26 weeks. (*c*) Maternity benefit, full wages for 4 weeks before and 8 weeks after confinement. (*d*) Optional nursing benefit, one-fourth wages for 8 months. (*e*) Funeral benefit, 30 to 50 times daily wage. (*f*) Dependants, similar benefits optional.
Lithuania ..	District sick funds	All wage-earners in industry, commerce and domestic service.	Contributions payable in equal proportions by employers and employees ; total monthly contribution varying between 5·40 and 21·60 litas according to wage classes. Cost of maternity benefits borne by State.	(*a*) Medical attendance and medicine for 26 weeks. (*b*) Sick pay from 50 to 100 per cent. of wages for 26 weeks if the worker has been insured for 6 months. (*c*) Maternity benefit equal to sick pay for 2 weeks before and 6 weeks after confinement if the woman has been insured for 6 months ; also a lump sum of 50 litas. (*d*) Nursing benefit ; 80 per cent. of sick pay for 13 weeks. (*e*) Funeral benefit ; 20 to 30 per cent. of daily wage. (*f*) Dependants receive medical attendance, medicine and maternity benefit and funeral benefit.

Country.	Method or Organisation.	Scope of System.	Source of Income.	Benefits.
Luxemburg ..	Establishment funds and district funds under supervision of the State.	All employed persons excepting agricultural workers, domestic servants and nonmanual workers earning more than 10,000 francs a year. Insurance is voluntary for domestic servants.	Contributions normally up to 4·5 per cent. of wages, but may be raised to 6·75 per cent., payable one-third by employers, and two-thirds by employees. Half the administration expenses of the district funds borne by the State.	(*a*) Medical attendance and medicine for 26 weeks. (*b*) Sick pay, one-half average wage for 26 weeks. (*c*) Hospital treatment with half sick pay. (*d*) Maternity benefit, sick pay for 12 weeks medical attendance. (*e*) Nursing benefit, half sick pay for 12 weeks. (*f*) Funeral benefit, one-fifteenth of annual earnings.
Norway ..	National Insurance Office Local fund in each municipality or town. Establishment funds. Private funds.	All workers in public and private services over 15 years of age, and other persons with incomes under 6,000 kr. per annum. Employees classified according to income.	Contribution fixed by local fund. Compulsorily insured person pays 6/9ths, employer 1/9th, state 1/9th, and municipality 1/9th.	(*a*) Medical attendance, surgical appliances and hospital treatment for dependants also. (*b*) Sick pay from 0·80 Kr. to 4 kr. per day, maximum 26 weeks in any one year and 39 weeks for the same sickness. (*c*) Maternity benefit : nursing care and allowances at same rate as 6 weeks after confinement. (*d*) Funeral benefit up to 75 kr. (*e*) Member's wife, maternity benefit, midwife and 30 kr.
Poland ..	District sick funds under supervision of the Central Social Insurance Institute.	All workers of both sexes, including domestic servants, and homeworkers whose remuneration does not exceed 750 zloty per month. Employers classified according to wages. Agricultural workers not included.	Contributions, 5 per cent. of wage not exceeding 174 zloty per week. Contributions payable in equal proportions by emloyer and employee.	(*a*) Medical attendance, medicine, dressings, for 26 weeks. (*b*) Sick pay, 50 per cent. of basic wage for 26 weeks. (*c*) Maternity benefit, medical attendance, and midwife, and full basic wage for 8 weeks. (*d*) Nursing benefit for 12 weeks. (*e*) Funeral benefit, 3 times basic weekly wage. (*f*) Dependants, medical attendance for 13 weeks, maternity and nursing benefits.

Portugal ..	Funds established by corporations in virtue of collective agreements.	All members of trade unions covered by agreements.	Contributions of employers and employees, fixed by agreements.	According to terms of agreements. Sickness benefit and medical benefit granted for a maximum period of 36 weeks.
Rumania ..	Territorial insurance funds ..	All employed persons whose earnings do not exceed 6,000 lei per month and persons of small means working on their own account.	Weekly contribution varying from 8 to 18 lei according to basic wage payable in equal proportions by employer and employee. State subsidy fixed at 40 million lei for 1935.	(*a*) Medical attendance and medicines for the insured person and his dependants. (*b*) Sick pay, 50 per cent. of basic wage (maximum 120 lei per day) for 26 weeks. (*c*) Maternity benefit ; medical attendance and medicines for the insured woman, or wife of insured person. Insured woman also receives sick pay for 6 weeks before and 6 weeks after confinement together with a nursing benefit. (*d*) Funeral benefit, 2,000 to 5,000 lei according to wage class.
United Kingdom	Ministry of Health (England and Wales). Department of Health (Scotland). Ministry of Labour (Northern Ireland). Country Insurance Committees Approved societies. Deposit contributors.	All employed persons, of both sexes, over 16 years of age, and under 65 for men and under 60 for women, expecting those employed otherwise than by way of manual labour with incomes over £420 per annum.	Employee, man, 5½d ; woman 5d. per week ; employer, 5½d. Where wages do not exceed 4s. per day employer pays a larger proportion, and where they do not exceed 3s. employer pays the whole.	(*a*) Medical attendance and medicine. (*b*) Sick pay, 18s. per week for men, 15 s. for unmarried women, 13 s. for married women, for 26 weeks. (*c*) Disablement benefit at half sick pay, after expiration of sick pay. (*d*) Maternity benefit, £4 for insured women, £2 for wife of insured man.
U. S. S. R.	Administered by Central Trade Union Council and 163 affiliated trade Union federations and their local branches.	All employed persons	Employer pays all contributions, which are fixed by orders of the Council of people's Commissaries according to the degree of risk incurred in each occupation.	(*a*) Medical and hospital treatment and medicine. (*b*) Sick pay from two-thirds to 100 per cent. of wage according to kind of work, trade union status and qualifying period of employment.

Country.	Method of Organisation.	Scope of System.	Source of Income.	Benefits.
				(*c*) Maternity benefit, sick pay, for 55 days before and 56 days after confinement for manual workers and 42 days before and 42 days after confinement for intellectual workers. (*d*) Nursing benefit of 45 roubles. (*e*) Layette allowance of 32 roubles. (*f*) Funeral benefit, 40 roubles (20 roubles on death of child) for funeral in towns and 20 roubles (10 roubles on death of child) for funeral in the country.
Yugoslavia ..	Central Worker's insurance institution. Local Workers' insurance institutions. Workers' insurance funds for transport undertakings. Miners' mutual benefit societies.	All persons who perform physical or mental work for remuneration, including home workers and seamen. Agricultural workers not yet included.	Contributions not exceeding 7 per cent. of the basic daily wage. Employer and employee each pays one half of the contributions. The State pays an annual Contribution towards administrative expenses.	(*a*) Medical attendance, medicine, baths, etc., for 26 weeks. (*b*) Sick pay, two-thirds basic wage for 26 weeks. (*c*) Maternity benefit, medical attendance and midwife and three-quarters basic wage for 6 weeks before and 6 weeks after confinement. (*d*) Nursing benefit, half basic wage for 20 weeks. (*e*) Child endowment, 14 times basic wage. (*f*) Funeral benefit, 30 times basic wage. (*g*) Dependants, medical attendance, maternity and nursing benefits.

N.B.—The above information is collated from various sources and shows the pre-war position.

APPENDIX XXII.—Proposals regarding Maternity Benefit.

The International Labour Convention concerning the "Employment of Women before and after Childbirth" provids for a series of prohibitions and confers certain rights upon female workers. These include the following: (1) Women are forbidden to work during the six weeks following their confinement; (2) they have the right to leave work on presentation of a medical certificate proving that they are likely to be confined within six weeks; (3) the employer is prohibited from giving a female worker notice of dismissal during the prescribed period of absence; (4) a female worker, while absent from her work on account of pregnancy of confinement must be paid benefits sufficient for the full and healthy maintenance of herself and her child; (5) she is entitled to free attendance by a doctor or a certified midwife; and (6) she must, in any case, if she is nursing her child, be allowed half-an-hour twice a day during her working hours for this purpose. The provisions of this Convention have been adopted in different countries to varying extents, and the liability is charged either to the employer or, in rare cases, to the State. But wherever there is an organised system of compulsory sickness insurance, maternity insurance forms part of such a system. In some countries, where this is not available there are special schemes of maternity insurance. From the nature of the risks involved, there is no doubt that the insurance principle is best suited to the protection of child-bearing women workers instead of requiring their employer to take care of them. In India, maternity benefit legislation has preceded health insurance and naturally the question of applying the insurance principle to maternity could not be given full consideration, although the Royal Commission on Labour (*Report*, p. 264) had clearly indicated that maternity benefits could "form an integral part" of "any general scheme of sickness insurance", and also suggested that "in the event of any general scheme of social insurance being adopted, maternity benefits should be incorporated and the cost shared by the State, the employer and the worker". Before considering the problem of such incorporation of maternity benefits in the scheme however, it is necessary to describe the present position of the relevant legislation in India.

There is no all-India legislation on maternity benefits, although an abortive attempt was made in 1924 by a private member to propose this in the Legislative Assembly. The first measure of Provincial Legislation was the Bombay Maternity Benefit Act of 1929 and this was followed by similar enactments in the Central Provinces (1930), Madras (1934), U. P. (1938), Bengal (1939), Punjab (1943) and Assam (1944). On the separation of Sind from Bombay, Sind re-adopted the Bombay Act in 1939. The Bombay Act was with modifications extended to Ajmer-Merwara (1932), and to Delhi (1937). These Acts apply to factories only, seasonal as well as non-seasonal, in Bombay, Sind, Bengal, C. P. and Berar; and non-seasonal, in U. P., Madras and Bengal. In some of the native States also, there are similar Acts, which mainly follow the Provincial Acts, with minor modifications. Hyderabad introduced maternity legislation in 1942; Baroda in 1932; Mysore in 1937; Indore in 1936. In Gwalior, the relevant Act is awaiting the H. H.'s assent, while in Travancore although an Act has been passed, it appears that it has not yet come into force. In order that a woman worker may be entitled to claim benefits, she must satisfy the condition regarding a qualifying period. In Bombay, Bengal and the Central Provinces, a woman worker becomes eligible only if she has been employed in any factory or factories of the employer concerned for a total period of not less than nine months immediately preceding the date on which she gives a notice regarding pregnancy and claim maternity benefits. The qualifying period in the United Provinces is only 6 months. In order to get over the complaint of workers that employers had refused to pay the benefit on the ground that the claimant had not put in a *continuous* service for 9 months without any break of more than 14 days, the Madras Act was recently amended, and it now provideds that the claimant should have been employed in any factory or factories of the employer concerned for not less than 240 days within a year immediately preceding the date on which notice of confinement was given. The claimant is also required under the various Acts to give a notice stating that she expects to be confined within one month next following the date of notice, and also to furnish proof of her delivery later. The woman worker is entitled to the payment of maternity benefit for the actual days of her absence, not exceeding four weeks, during the period immediately preceding her confinement and four weeks immediately following it in Bombay, Sind, Bengal, C. P. and Berar and U. P.; while in Madras the maximum period for which benefits can be claimed is only three weeks before and four weeks after confinement. The rate at which benefit is to be given is 8 annas per day in Madras and in the cities of Bombay, Ahmedabad and Karachi. In other parts of Bombay and Sind, and in C. P. and Berar, the benefit rate is 8 annas a day or the average dialy earnings during the preceding three months, whichever is less. In U. P. and Bengal, the rate is 8 annas per day or the average daily wage, whichever is higher. Some other benefits are granted in U. P. A woman worker in a factory becomes entitled to 3 weeks' leave with pay from the day of her miscarriage, Again, a woman worker, who avails herself of the services of a qualified midwife or trained woman health visitor at the time of her confinement, is entitled to a bonus of Rs. 5. Two more important features of the Acts are: (1) that the liability is placed upon the employer alone for payment of benefits, and (2) that the employer is prevented from giving notice of dismissal to a woman worker during period of maternity benefit, and, in some Provinces, for some months preceding confinement. We shall discuss the question of "employers' liability" as as awell as that of "dismissal" presently.

It would appear from the foregoing description of the existing legislation that maternity benefits are provided in almost all the major industrialised provinces for factory workers. However, serious defects have crept into the administration of the benefits. It is not the case really that there are any defects in the legislation as such; for this is quite on par with similar legislation elsewhere. The defects have arisen very largely as a consequence of making the employer responsible for payment of benefits, and in fact recent amendments in some of the Provincial Acts have been directed to closing loopholes

arising from the principle of employer's liability. It cannot be said, however, that the aim has been successful. The main defects of the existing legislation are as follows: (1) In the first place, the legislation is neither quite uniform nor universal, so that there are gaps here and there, which cannot be said to be fair to the workers. (2) Secondly, only cash benefit is given at present, and there is no provision for medical benefit of ay kind, the worker being left to her own resources for this. (3) Thirdly, it is clear that evasion is still widely prevalent, either owing to loopholes in the law or other causes. The Bombay Textile Labour Enquiry Committee mention the existence of evasion (*Report*, pp. 307-8) arising from the condition of qualifying period, which has been held by some employers to have been broken when there was a break in service on account of absence without leave. The same difficulty had arisen in Madras (*vide* Report of the Court of Enquiry, Coimbatore, in *Madras Labour*, July 1937—October 1938, pp. 159—161), where the Act was revised as stated in the previous paragraph. Apart from this, however, there are other avenues of evasion. For example, in some Provinces, it is possible for the employer to dismiss a woman worker on the first signs of pregnancy. Only in Madras and Bengal, there are provisions partially preventig the employer from doing so. The Madras provision is thus worded: — "No notice of dismissal given without sufficient cause by an employer to a woman within a period of five months before her confinement shall have the effect of depriving her of any maternity benefit to which but for such notice she should have been, or would on or before the date of her confinement have become, entitled under this Act." The Bengal provision is identical, except that the prohibited period is six months instead of five. But even then, the threat of subsequent dismissal, *i.e.*, if benefit is claimed, is still possible. It was stated by workers' representatives that due to the fear of such subsequent dismissal most women workers preferred not to put in claims. Official opinion on this point (quoted in Appendix XXV) is rather conflicting, but, on the whole, it appears that, although there is quite a large number of employers who abide by the provisions of the Acts and, in some cases, go even further, there are considerable opportunities for evasion. If reference is made to Appendix XXIV which gives statistics for the important Provinces, it will be seen that there is considerable disparity in the maternity benefit ratios (*i.e.*, the ratios of number of claims paid to total number of women workers employed) as between the different Provinces, which cannot be explained away by any differences of fertility or technical factors. Thus, the average ratio (over a period of years) in the case of Bengal was 7·6 per cent; Bombay, 7·3 per cent.; C. P. & Berar 12·7 per cent; Madras 3 per cent; and U. P., 4·7 per cent. In this connection, it is interesting to note that in a Bombay Labour Office Enquiry (*Cf. Labour Gazette*, 1924, pp. 384-93), it was found that there were 12·34 maternity cases per 100 women workers per annum, as compared to 10 maternity cases per 100 "potential mothers" among all classes, in the city of Bombay, as discovered by Dr. Mrs. Barnes in another enquiry (*Cf. Labour Gazette*, September 1922). It was also found that more than half the expectant mothers left the place of work two months before confinement. By the standard of this enquiry, all but the C. P. figures make a poor show, and, in fact, Madras, which is known to have a high female fertility, shows a very great probability of evasion. In fact, the Court of Enquiry, Coimbatore (*Ibid*, p. 159) also expresses surprise that in a place like Coimbatore, (which is in a high fertility population zone) the recipients of benefits should be only 2 per cent. of the total number of women employed in 1936 and 3 per cent. in 1937. The figures for U. P., Bombay, and Bengal are also suspicious. It is not suggested that the non-enforcement of the Acts has always been the result of evasion; in many cases, it has been also due to ignorance on the part of the women workers as to their rights, while in a few cases, as mentioned by the Chief Inspector of Factories, Bombay, (See Appendix XXV) women workers are stated to have refused the employer's "charity". (4) Fourthly, it is suggested by many that as a direct consequence of the passing of Maternity Benefit Acts, the employment of women in factories has been somewhat discouraged. The statistical evidence on this point, however, is not quite conclusive, as will be seen by a reference to Appendix XXIV (A). There may have been other factors at work also, such as the technical factor (*viz.*, the fact that certain types of work are more suitable for women and others for men, and relative fluctuations in the fortunes of such types of work), non-availability of male labour due to the demands of war, etc. But, even if we bear these points in mind, there seems to be some truth in the contention, especially in the case of those Provinces in which the Acts are being more rigorously enforced. Apart from statistical evidence, it is rational to presume that employers would prefer to engage either men, or women who were widowed or unmarried, if it is going to be their liability to pay cash benefits; and in the course of my discussions this presumption was corroborated even by some employers, while most workers' representatives were definite on the point. (5) Finally, there is no official or unofficial machinery for educating the women workers in regard to their rights and protecting their interests, while the woman worker herself is not always prepared to fight the issue, seeing that the pittance to be obtained is so small (as compared to, say, workmen's compensation, about which there have been more complaints and litigation) relatively to the prospects of permanent employment.

In view of the foregoing discussion, it would be clear that there would be considerable advantage in bringing maternity benefit under the present Scheme. In the first place, such inclusion would automatically secure uniformity and universality in respect of treatment of maternity. Secondly, it will put an end to some of the malpractices which seem to prevail in the administration of maternity benefits. Thirdly, there will be a continuity of treatment on the medical side. This will help us to avoid the anomaly which must arise from the position that the female worker would be taking care of herself during maternity (under the present arrangement) and would have to be looked after by the health insurance institution both before and after the period covered by the maternity laws. Apart from the possibilities of overlapping, the female workers themselves will not know whether under particular circumstances they are or are not entitled to be treated at the health centres. Fourthly, amalgamation of maternity benefit with health insurance will also be advantageous from the employer's point of view, as he will be

relieved of the responsibility of providing cash benefits and observing the legal formulae prescribed by the Acts, and in a single payment he will be able to deal with both matters. Fifthly, a good part of female sickness is connected with maternity, which if properly controlled and supervised, might reduce the women workers' sickness rates in a very direct manner. Finally, in any case, the health insurance institution will have to undertake the responsibility of providing maternity benefit in Provinces (and such States as may join) which have no maternity benefit legislation, not only because such facilities are desirable from the workers' standpoint, but because they will be necessary to keep down the total morbidity experience. It is impossible to draw a line of demarcation between maternity and sickness arising from maternity on the one hand, and between sickness arising from maternity and other ordinary sickness on the other. A doctor, who is asked to certify ordinary sickness will be at a loss when there is any gynaecological complication. He may even be tempted to certify puerperal sickness as ordinary sickness. If he is allowed to include puerperal sickness for purposes of certification, he will be subjected to temptation to certify even maternity as such sickness. Thus it becomes inescapable that the doctor should be allowed to certify all the three types of sicknesses for payment of cash benefit. In *non-legislating* Provinces and States, therefore, in the absence of maternity benefit legislation, the responsibility for payment of cash benefit for maternity may surreptitiously devolve upon the health insurance funds.

The possible objections to amalgamation are few. Thus, it has been suggested that the existing arrangement, at least in the legislating Provinces and States, should be left undisturbed.* The existing maternity benefit legislation, it has been pointed out, applies to all factories, perennial as well a seasonal in some cases, and only perennial in others, while the present scheme at least in the beginning may not have such a wide scope. This difficulty, however, cannot be serious, and even if in the beginning health insurance has a more restricted application than the existing maternity benefit Acts, it would be quite feasible to take over maternity benefit in the case of factories falling within its scope, leaving the others for the time being to remain under the operation of the existing Acts. At a later stage, of course, it will be possible to extend the scope of health insurance to all female workers. Labour opinion is generally in favour of bringing maternity benefit under health insurance, subject to two safeguards. Firstly, labour representatives are afraid that such inclusion might involve an addition to the workers's contribution, whereas at present the employer is liable for payment of maternity benefit. *As will be presently seen, however, the total expenditure on account of maternity cash and medical benefit is not likey to be more than a small proportion of the total health insurance expenditure; and, in any case, the relative shares of employers and workers in the total health insurance expenditure are not based upon any nice calculations but after taking into consideration the general position of both. This point, therefore, need not be pressed further. Another consideration urged by workers' representatives has been that in the event of inclusion of maternity benefit under health insurance, the female workers must not lose any of the rights enjoyed by them under the existing Acts. In particular, they are anxious that the present cash benefit of As. 8 should not be reduced, and that the period of maternity benefit should not be less than the average period enjoyed by the female workers at present, *viz* eight weeks. There is no difficulty in accepting this suggestion. Finally, I may mention a purely technical objection based by some of the witnesses interviewed by me, who questioned the propriety of including maternity within health insurance on the ground that maternity was not "sickness". Apart from the fact that maternity is "natural" sickness and that in several countries, it is dealt with under health insurance as such, the definition of "sickness" itself under the Act will be a special one covering all physical incapacity which necessitates absence from work. Whether or not absence from work is necessary in a particular case will be for the doctors to decide, and from that viewpoint, maternity can be regarded as sickness within the meaning of the health insurance law. Much depends, therefore, upon the policy decided upon in relation to maternity and upon the definition of sickness adopted. Under the British health insurance law childbirth is not regarded as sickness for the purposes of medical treatment except under certain circumstances, and only lump-sum cash benefit is given, but in several other countries (cf. *Compulsory Sickness Insurance* pp. 341 ff.) it is almost on par with other sickness. It is clear that the position regarding availability of maternity services differs from country to country and this has led to variation in practice. So far as India is concerned, I feel that it is imperative that medical benefit to women before, during and after maternity should be provided under a unified scheme not only with a view to provision of a much-neglected facility but also with a view to minimisation of the morbidity experience of women workers.

Even if cash maternity benefit, with leave, is given to the female workers, the more important problem of providing obstetrical assistance still remains. This is a much neglected aspect of maternity welfare. At present, the female worker is left to fend for herself so far as actual confinement is concerned, while there is little or no provision for ante-natal and post-natal care. Only in one or two Provinces, the female worker gets a small additional bonus, if she engages a trained *dai* or nurse. In view of the fact that in several countries, where health insurance is in force, obstetrical assistance is regarded as a part of health insurance work, and in view of the special circumstances, mentioned above, which arise in India, there is no reason why such assistance should not be given through the agency of health insurance. Of course, in the beginning, it might prove difficult to provide a sufficient number of maternity homes so as to cover the entire class of women workers, but there should be no difficulty in making a beginning by way of provision of trained nurses and *dais* for free attendance on female workers during confinement. As the nurses and *dais* will be visiting the workers' own houses for such attendance the cost is not likely to be at all heavy. In view of the fact that only a small proportion of the female workers will be at any time in need of obstetrical attendance, the number of such nurses and *dais*

required in centres is not likely to be large. Later on, when funds permit, it should be possible, especially in the larger industrial centres, to establish maternity homes on modern lines. It should also be possible to extend the activities of the maternity homes to the sphere of child welfare, which is an urgent problem of the industrial workingclass population.

In overhauling the existing maternity benefit legislation and providing maternity benefit where it does not exist, the following provisions may be suggested: (*i*) In the beginning, maternity benefit should be given to female workers only, whether married, unmarried or widowed, working in factories covered by health insurance; (*ii*) there should be a qualifying period preceding the date of confinement, which can be best secured by the provision that the worker should have paid at least 9 monthly contributions during the 12 months preceding confinement; (*iii*) the amount of cash maternity shall be a sum of Rs. 28 (roughly equivalent to a daily rate of As. 8 for eight weeks); (*iv*) medical treatment and attendance may be provided in the form of attendance by nurses or *dais*, and, if funds permit, in selected areas through maternity homes, and, where neither is feasible, say, owing to the number of female workers being extremely small, a special bonus of Rs. 5 may be given in lieu of such attendance and treatment; (*v*) the female workers shall be entitled to ante-natal examination and, if necessary, post-natal treatment also at the health centres etc; (*vi*) if treatment is given at a maternity home at the expense of the health insurance institution, the cash benefit may be reduced by half; (*vii*) if incapacity extends beyond the maternity benefit period, the female worker shall be entitled to the ordinary sickness benefit if she is otherwise qualified for it, provided that the period of maternity benefit will be deducted from the total number of days (90 or 45, or any higher figure which may be decided upon later when the Act is revised) for which she is entitled to such benefit. (*viii*) detailed rules regarding employment and dismissal, notice of confinement, etc. may be laid down mainly along the lines of the existing Maternity Benefit Acts and of rules adopted here and in foreign countries, (*ix*) if and when funds permit, the scope of maternity insurnace may be extended so as to cover wives of workers, and to provide nursing bonuses etc.

The question which remains to be tackled is that of the financial implications of these proposals. The total number of female workers, adults, adolescents and girls employed in perennial factories during the years 1939, 1940 and 1941 was as under:—

TABLE 45.

Average daily number of women employed in all Industries.

	1939	1940	British India 1941
Adults Perennial Factories	164,825	168,572	182,851
Adolescents ,,	2,957	2,06	2,777
Children ,,	1,650	1,673	1,745
Total ,,	169,432	173,151	187,373
Adults Seasonal Factories	74,589	74,892	79,231
Adolescents ,,	1,145	754	1,003
Children ,,	442	492	426
Total ,,	76,176	76,138	80,710
Grand total—Perennial and Seasonal Factories	245,603	249,283	268,083

The above Table indicates that the total number of female workers covered by the scheme will be in the neighbourhood of 2 lakhs. Assuming, on the basis of the Bombay experience of 12 per cent mentioned above, the number of confinements in a year will be nearly 24,000. Many of these would be disqualified under the rules for one reason or another. We may assume that there are about 4,000 cases of disqualifications, leaving a balance of 20,000. The liability on the health insurance fund will, thus, amount to Rs. 5,60,000 per annum in respect of cash maternity benefit. I am not in a position to make a correct estimate for the cost of obstetrical attendence, but I am inclined to believe that it will not exceed Rs. 4 or 5 lakhs, for attendance by nurses and *dais*, and recurring expenses of maternity homes in important industrial centres. A total amount of Rs. 10 lakhs, therefore, will be needed annually for providing maternity benefit for industrial female workers throughout British India. It is not possible at this stage to make any estimate for the States. But it must be remembered that this total amount of Rs. 10 lakhs will be required, if the entire maternity benefit machinery working at present is replaced, and that this expenditure will not be wholly in addition to the expenditure incurred at present by employers and workers, but mainly in lieu of it. We must also consider the probability that a considerable number of women might prefer to go to their villages for confinement, while others might not like treatment in maternity homes. In the beginning therefore, we should expect a large saving on the medical side of maternity benefit. Not that this is desirable, but it would certainly provide some breathing-space for further planning.

If it is accepted that Maternity Benefit should be an integral part of the Health Insurance Scheme, the immediate question to be considered will be the provision of the necessary finance, viz., Rs. 10 lakhs. I may suggest that this amount should be raised by making a small addition to the employers' contribution at a later stage. This will leave the financial structure of contributions and benefits erected for health insurance in the present scheme undisturbed.

APPENDIX XXIII.—Maternity Benefit.

TABLE 46.—*Comparative Statement showing some of the important Legislative Provisions regarding Maternity Benefit at present in force in the Provinces and States and in the Mines.**

Province.	Year in which passed.	Qualifying period (Months).	Maximum period for maternity benefits (Weeks).	Rate of maternity benefits.
Bombay	1929	9	8	8 annas a day or average daily wages, whichever is less. But in the Cities of Bombay and Ahmedabad 8 annas a day.†
C. P. & Berar	1930	9	8	8 annas a day or average daily wages, whichever is less.
Madras	1934	240 days (8 months) within a period of one year.	7	8 annas a day.
U. P.	1938	6	8	8 annas a day or average daily wages, whichever is greater.
Bengal	1939	9	8	Do. do.
Punjab	1943	9	60 days	12 annas a day.
Mines (under the Indian Mines Maternity Benefit Act)	1941	6	8	8 annas a day.
Assam	1944	150 days	8	1. In plantations Re. 1 per week for the period before confinement and Re. 1/4 per week for the period after confinement, provided the total cash payment is Rs. 14. 2. In other employments Rs. 2 per week or average weekly wage or salary whichever is greater.

[From *Indian Labour Gazette*, May 1944, p. 287.

*Some Indian States also have enacted Maternity Benefit legislation. These Acts in the States are based on the legislation in the British Indian Provinces. Information regarding the important States is given below.

Baroda.—With certain modifications the Bombay Maternity Benefit Act is made applicable in the Baroda State. The rate of benefit is 6 as. against 8 as. in the Bombay Act. *Cochin.*—Follows the Madras Maternity Benefit Act, 1934 (as modified up to the 1st December 1939). The Cochin Act, however, introduced the following changes. While the Madras Act provides benefit of 8 as. the Cochin Act provides benefit of only 3 as. In the Madras Act, the minimum period of employment for maternity benefit is 240 days; but in the Cochin Act it is 12 months. The maximum period for which a woman is entitled to maternity benefit is, in Madras 7 weeks and in Cochin 8 weeks. *Gwalior.*—The Act is awaiting His Highness' assent. *Hyderabad.*—Follows the Bombay Act in general. *Indore and Mysore*—The Acts in these two States follow the general principles of the Bombay Act. *Travancore.*—A Maternity Benefit Act has been passed but it appears yet not to have come into force.

†It is understood that for the duration of the war, the Millowners' Association Bombay has increased the rate to As. 12 per day. The Ahmedabad Millowners' Association also has, it appears, issued a recommendation to its members to the same effect.

APPENDIX XXIV-A.

TABLE 47.—*Employment of Female Workers as Percentage of Total Employment and Recipients of Maternity Benefits as Percentage of Women Employed in Factories subject to Maternity Benefit Acts.**

Province and Year.	Total Number of male and female workers employed in factories subject to Maternity Benefit Act.	Number of female workers in same.	Percentage of (3) to (2)	Number of female workers who were paid benefits.	Percentage of (5) to (3).
(1)	(2)	(3)	(4)	(5)	(6)
1. *Bengal***					
1940	417,026	51,291	12·3	3,716	7·4
1941	424,733	50,698	11·9	3,995	7·8
2. *Bombay***					
1-7-1929 to 30-6-1930	258,085	52,733	20·4	1,692	3·2
1-7-1930 to 30-6-1931	268,416	51,412	19·1	5,139	9·9
1-7-1931 to 30-6-1932	232,118	52,979	22·5	5,377	10·0
1-7-1933 to 31-12-1933 (*a*) ..	(*b*)	43,394	(*b*)	2,675	(*b*)
1934	244,897	44,693	18·2...	4,089	9·1
1935	278,591	48,686	17·4	3,845	7·8
1936	302,992	44,171	14·5	4,310	9·7
1937	301,685	47,023	15·8	3,580	7·4
1938	327,362	52,400	16·0	3,888	7·4
1939	294,665	47,381	16·0	4,381	9·2
1940	290,446	44,731	15·4	3,956	8·8
1941	363,238	53,998	14·8	3,991	7·3
1942	367,110	49,923	13·5	4,425	8·0
3. *C. P. & Berar***					
1931	23,773	4,319	18·1	498	11·5
1932	23,616	4,187	17·7	605	14·4
1933	22,537	4,157	18·4	430	10·3
1934	23,183	3,968	17·1	511	12·9
1935	24,733	4,556	18·4	507	11·1
1936	24,484	4,886	19·8	513	10·4
1937	24,514	5,138	20·9	612	11·9
1938	27,281	5,956	21·8	645	10·8
1939	28,029	5,617	20·0	793	14·1
1940	28,927	5,431	18·7	766	14·1
1941	32,827	5,311	16·0	814	15·3
1942	36,133	5,616	15·5	890	15·8
4. *Madras***					
1935	163,021	28,184	20·7	356	1·2
1936	169,964	30,324	21·4	946	3·4
1937	195,046	37,460 (*c*)	23·4	928	2·4
1938	202,167	38,070	23·2	1,211	3·1
1939	207,392	39,776 (*c*)	23·6	1,416	3·5
1940	222,580	42,045	23·3 (*d*)	1,678	3·9
1941	246,775	43,773 (*c*)	21·5 (*d*)	1,687	3·8
5. *U. P.*					
1938	104,601	2,741	2·6	(*b*)	(*b*)
1939	108,537	2,544	2·3	(*b*)	(*b*)
1940	132,272	2,275	1·7	143	6·2
1941	174,025	3,093	1·8	117	3·7
1942	182,403	3,394	1·9	145	4·2

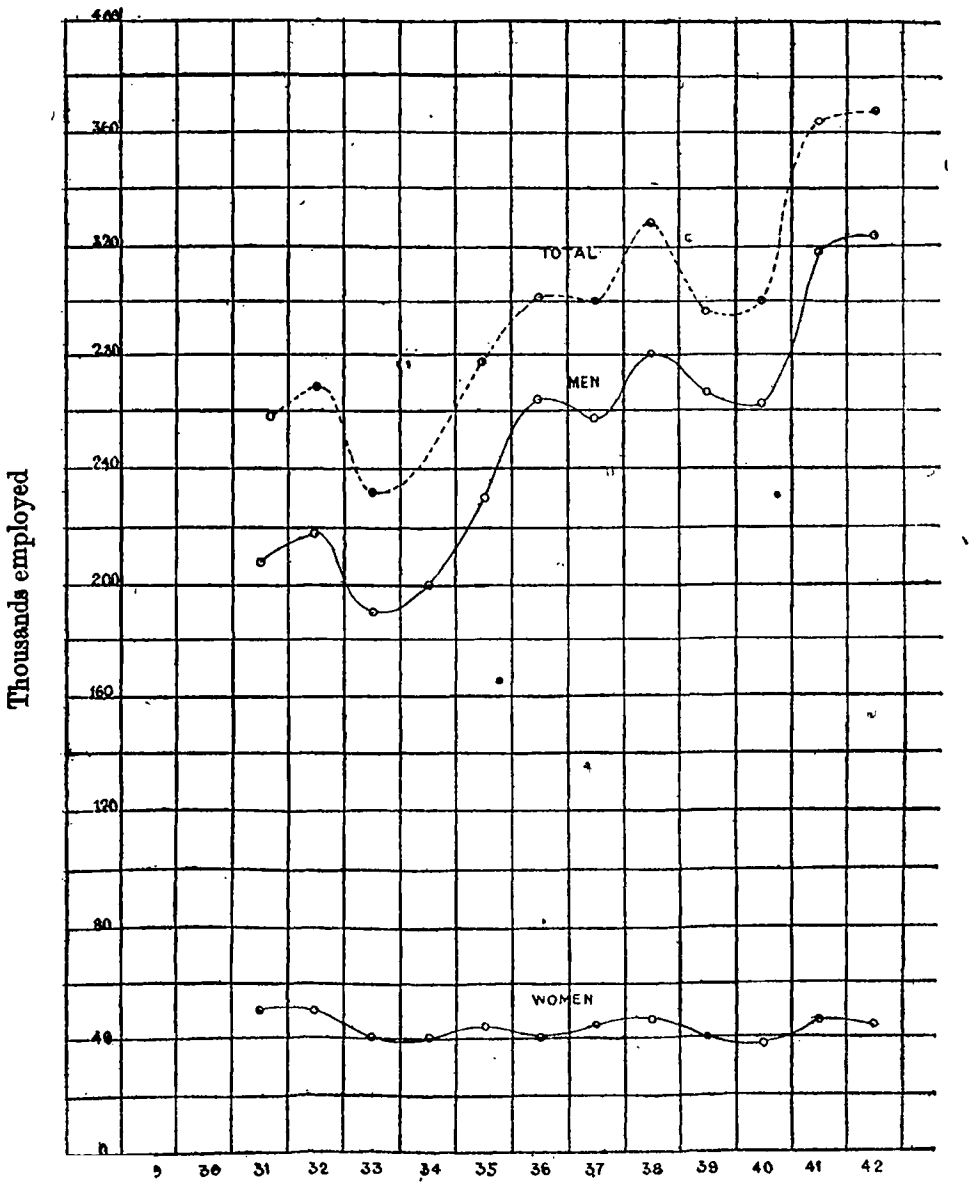
*Figures obtained from Provincial Governments.

**Act came into force in Bengal on 1st January 1940, in Bombay on 1st July 1929, in C.P. on 1st January 1939, in Bihar on 15th June 1931, in Madras on 1st April 1935 and in U. P. on 1st September 1939.

(*a*) For six months only. (*b*) Figures not available. (*c*) Decrease is ascribed to non-receipt of return under the Factories Act. (*d*) Decrease is ascribed to non-receipt of return under the Madras Maternity Benefit Act.

APPENDIX XXIV-B.

EMPLOYMENT IN COTTON MILLS BOMBAY PROVINCE



[*Supplied by Chief Inspector of Factories, Bombay.*]

APPENDIX XXV—EXTRACTS FROM OFFICIAL LETTERS AND REPORTS RELATING TO MATERNITY BENEFIT.

1. [Extract from letter No. C 592/43 dated the 26th May, 1943, from F. R. Brislee, Esqr., I.C.S., Commissioner of Labour and Chief Inspector of Factories, Madras.]

The Court of Enquiry appointed by the Government in 1938 to enquire into the disputes between the employers and employees of the textile mills in Coimbatore reported that many applications for the maternity benefit were rejected on the ground that the claimants were absent without leave for more than 14 days during the qualifying service of 9 months prior to notice under section 6 following the executive instructions issued by this department and commented on the low percentage of maternity benefits paid in 1936 and 1937. The Court, therefore, recommended to the Government that the nine months' service should be within a period of one year or 18 months prior to the date of notice. In view of the Court's recommendation and with a view to have a specific provision in the Act itself which would be uniform in its application, the proviso to section 5 (1) was amended so as to make a woman worker eligible for the maternity benefit if she was employed in any factory or factories of the employer concerned for not less than 240 days within a period of one year immediately preceding the date on which she gave notice of her intention to claim maternity benefit.

Although under section 8 (2) of the Act no notice of dismissal given without sufficient cause to a woman worker within a period of 3 months before the confinement could deprive her of the maternity benefit to which she would have been otherwise entitled, it was apprehended that some of the factory owners might evade their obligations under the Act by dismissing women workers at the very first sign of pregnancy. To prevent this, the period was extended from 3 months to 5 months.

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2. [Extract from letter No. 4956/F dated the 27th May 1943, from P. T. Koman Nair, Esq., B.A., B.Sc., Chief Inspector of Factories, C. P. & Berar.]

The complaint that workers are dismissed before they are able to give notice under the Act and that the tendency is to employ less and less female workers are neither of them new ones. These may appear to be the natural reaction of employers to the legislation but there is no evidence to prove that this is taking place on any considerable scale. Petty employers may be offenders, in many ways on small matters but as general conclusions cannot be drawn on isolated instances, such cases can be ignored.

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3. [Extract from letter No. 2193 dated the 31st May 1943 from R. C. Parsons, Esq., B.Sc., A.M.I. Mech. E., A.M.I.E.R., Chief Inspector of Factories, Bengal.]

Although the statistics of employment suggest a certain tendency on the part of employers to dispense with female labour yet there have been no complaints alleging dismissal of expectant workers in order to obviate payment of maternity benefit.

Whenever a special class of labour is vouchsafed special protection there is naturally always a tendency to dispense with such labour if the work involved *can be carried out by any other class* not subject to such special administrative attention. For instance, during the year 1925 a total of 3,851 children were employed in Bengal factories whereas in 1941 only 1,319 were employed.

Jute, however, is the principal employer of female labour in Bengal and in view of the reluctance of male employees of that industry to work without their wives, the comparatively small reduction in female employment indicated in the 1940-41 reports cannot be attributed to the influence of the Bengal Maternity Benefit Act.

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4. [Extract from the Report on the Administration of the Bengal Maternity Benefit Act for the year 1940.]

The figures for the different industries given in Appendix 1 are very enlightening, They disclose that in certain of the smaller industries employers are either evading their responsibilities or, otherwise female employment, is so intermittent as to preclude conformity with the prerequisite of maternity benefit pay, i.e., nine months' continuous service prior to childbirth. Sufficient information, however, has become available to suggest that, particularly in rice mills, not only do the women workers remain in ignorance of the protection due to them under this Act but that the employers are not meeting their obligations in the matter of benefit payments.....

Complaints.—A few complaints were received during the year but in the majority of cases they had reference to benefit claims where the requisite nine months' service prior to childbirth was open to dispute. Several, however, arose through the failure of the women concerned to give their respective employers notice of expectation of confinement the result being that the employers had no knowledge of their condition. In all cases, however, the interest of the Inspector had the effect of obtaining maternity benefit for the women concerned whether legally due or otherwise.

General.—In the course of administration certain defects in the provisions of the Act have been observed although, on the whole, they cannot be considered as of very great importance.

Section 3, for instance, reacts unfavourably on the woman worker who is about to give birth or has given birth to a child but, through failure to establish *nine months'* service with her employer, can neither claim benefit nor be allowed to work.

Also in the proviso to clause (1) of section 4, the expression " employed.....for a period of not less than nine months immediately preceding the day of her delivery " presents difficulties in interpretation in cases where employment during the period is interrupted by illness, lack of work and the like.

" It has been suggested, also, that since the standard of living of all women workers and the expenses associated with confinement are more or less the same, it is inequitable that the benefit should be based on an estimate of average earnings, thereby permitting one woman to receive much greater benefit than another. *A flat rate, irrespective of average earnings,* would apparently make for greater contentment and would be more equitable in the circumstances.

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5. [Extracts from Report on the Administration of the Bengal Maternity Benefit Act, for the year 1941.]

As mentioned in the report of last year, however, in all large concerns and no matter what the industry where women are employed, there is little doubt that the provisions of the Act are strictly observed and interpreted with benevolence with respect to claims not precisely circumscribed by the four corners of the Act. It may also be observed with respect to the smaller type of establishment that where claims have been accepted and benefit paid the Act has on the whole been adhered to although perhaps not with the same generosity with respect to doubtful cases as with the larger and wealthier concerns. An employer who accepts a claim does recognise his legal responsibilities and the latter being achieved there can be little reason for doubting the accuracy of his records and returns.

As regards concerns, however, which have by virtute of statements in their return consistently denied the existence of maternity with respect to their female workers although the circumstances are in no apparent degree different from those of factories in which maternity has been admitted, it is obvious that evasion is deliberately being practised. In this connection attention is directed to those industries of Statement I in which no claims are alleged to have been made and in particular the *rice mill* industry.

It as evident, therefore, as soon as conditions become normal and the Factories Department staff relieved of its present additional burdens arising out of the war, that this industry together with others bracketed with these adverse remarks will have to be subjected to more than routine attention.

Complaints.—Four complaints were received during the year respecting non-payment of benefit. These were all borderline cases in which the question of nine months' employment of the proviso to subsection (1) of section 4 was generally involved. In two of these claims an appeal by the Inspector to the employer's generosity and compassion was effective in securing payment of benefit. In another claim, however, the employer remained unmoved although the circumstances were such as to warrant departure from the precise interpretation of the law, the claimant having been a victim of change of ownership of the factory and in consequence could neither satisfy either the one or the other employer with respect to the nine months' period of employment immediately preceding the day of her delivery.

General.—Although few difficulties have been experienced in administration it must be admitted that on account of heavy pressure of other important work the close contact which the Act requires has not been maintained. There are certain defects in the Act, however, which have been pointed out in the report of last year and to which may now be added that arising from *employment through contractors.* Assurance of benefit to women so employed depends to a great extent upon the maintenance with precision of the *Register of Workers and Wages* under the Factories and Payment of Wages Acts respectively and until that is secured contractor's workers will be deprived of the benefits and protection of the Act. Apart from these observations, however, as long as generous compromise prevails amongst employers generally with respect to doubtful claims, amendments would be hardly justified, at any rate not in present circumstances.

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6. [Extract from letter No. 57-Gen/359, dated the 2nd June 1943, from the Chief Inspector of Factories, Delhi and Ajmer-Merwara, Delhi.]

The administration of the Act has not presented any special difficulties and as far as Delhi is concerned the purpose of the Maternity Benefit Law has been fairly well fulfilled. The main reason for this is that soon after the Act was enforced a Lady Doctor was appointed as an Inspector under the Act. She works in an advisory capacity and acquaints the female operatives about the provisions of the Act. She also gives certificate that a woman is pregnant.

In Ajmer-Merwara, things were, however, somewhat different. The Bombay Act was made applicable in 1933 and in spite of the fact that the three cotton textile mills at Beawar were employing about 400 women workers not a single woman had claimed benefit under the Act. On enquiry I found that the women workers were ignorant of the provisions of the Act, because beyond that a copy of the Abstracts of the Act had been displayed nothing by way of acquainting the women workers of the provisions of the Act was done. I therefore, requested the Local Government to appoint a Lady Doctor as an Inspector under the Act similar to what had been done in Delhi. A Lady Doctor for Beawar was appointed in 1941 and in that year about eight women claimed benefit under the Act. The Lady Doctor in the beginning met with some opposition from the women workers who for certain reasons did not wish to listen to her. The women workers were also afraid of lodging a claim for fear of being discharged. All this has now disappeared as the women workers now know the Act and the protection the law gives them.

Both in Delhi and Ajmer-Merwara there has been no instance of a female worker having been dismissed just because she was going to be a mother and therefore entitled to benefit under the Act. Also number of female workers has practically remained constant in all the mills and has shown no diminution since the introduction of the Act.

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7. [Extract from letter No. 10484 dated the 15th December, 1943, from W.H. Phillips, Esq., Chief Inspector of Factories, Bombay.]

It is said that statistics can prove anything and those in connection with Maternity Benefit Act are probably more erratic and possibly misleading than others. I have supplied details for Bombay, Ahmedabad and Sholapur, the three main centres of the textiles industry in this Province, separately from other centres, because claims per 100 women employed in Bombay have always been lower than in Ahmedabad and Sholapur, even though Bombay Millowners' have treated claims if anything more sympathetically than in other towns. This appears to have been due to the greater number of widows and older women employed here. Strikes of course have been responsible for disqualifying claims in some cases, whilst in 1942 the war scale resulted in reduced employment of women in Bombay and in Ahmedabad the mills were closed for 3½ months following the arrest of Congress leaders. My views are that in the majority of the large factories women's claims have been sympathetically treated and in numerous cases those without a "legal" claim have received benefits and longer periods of leave before and after confinement than those required by the Act have been granted. The average ratio of benefits paid to women employed has not varied greatly in Bombay and Sholapur but in Ahmedabad it has definitely fallen and there appears to have been in many mills a definite policy of not engaging any new women workers although those still employed still have claims treated sympathetically.

It is in the smaller factories in outlying towns that there is some truth in the complaints regarding non-compliance with the Act, and women in some cases have undoubtedly refrained from making a claim rather than run the risk of discharge. Even in mills which have treated women well, cases have been found of Marwari women refusing to make claims as they considered it to be "charity". The Act has however worked for the benefit of the large majority of women employed especially when it is considered that the whole of the benefit comes out of the employers pockets. 57,046 cases of women receiving benefits were reported out of the average of about 50,000 women employed per year over a period of 13½ years.

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8. [Extract from *Statistics of Factories etc.* for 1939.]

The decline in the number of the women workers is apparently due to the reluctance of employer to employ persons who are subjected to special provisions involving a certain amount of additional responsibilities in the shape of maternity benefit, compulsory creches etc. The decrease is also partly due to changes in technical employment.

9. [Extract from *Statistics of Factories etc.*, for 1940.]

In the United Provinces, the decline in the number of women workers continued during the year, mainly due to the introduction of the Maternity Benefit Act when the employers preferred dispensing with the services of women and employing men or boys in stead.

APPENDIX XXVI.—Proposals regarding Workmen's Compensation.

It is not proposed to discuss here the question of merely overhauling the Workmen's Compensation Act; for this has admittedly become out-of-date in its scope and operation. It might appear that this is a subject falling outside my province. Yet the inauguration of health insurance in India cannot possibly leave the earlier measures of social security intact. From Chapter IX, Section H, it will have been apparent that owing to the provision of medical benefits, there will be considerable overlapping and interference with the existing operation of the Workmen's Compensation Act. Apart from this there will be other probable consequences of the new measure which deserve consideration.

In the first place, it is almost certain that risks which properly belong to workmen's compensation will be passed on to health insurance, unless the health insurance authorities are extremely vigilant. This would be particularly the case with industrial diseases and those border-line cases of accidents which may or may not have arisen "in the course of employment." Secondly, the health insurance authorities, as in Great Britain, will have frequently to resort to litigation in order to recoup themselves in respect of a compensation claim where the workers has already received cash benefit pending settlement of the claim from the Fund. Such litigation might often be costly and might bring the authorities into constant conflict with employers of their insurers. It is a well-known fact that the worker is both reluctant and unable to have recourse to litigation himself for various reasons which will be discussed in a moment. This must throw the responsibility of litigation inevitably upon the health insurance authorities. It is not enough to say that workmen's compensation injuries must be treated separately and are no concern of the Fund. Such a statement is too *simpliste*; for, whether a particular injury will or will not be covered by the Workmen's Compensation Act must itself be a matter of doubt until the issue is determined in a court of law or the claim is admitted by mutual consent. Thirdly, the facilities provided by health insurance might occasionally even give rise to corruption and collusion. For example, a worker might be influenced by his employer to say that a particular injury was received not in the course of employment but elsewhere, while it is also conceivable that an unscrupulous employer might bring pressure on health insurance officers in order to persuade them not to press for compensation. The financial consequences of these possibilities may be disastrous to the health insurance organisation,

The question, therefore, arises as to what precisely is to be done with the existing workmen's compensation legislation and the machinery erected thereunder. I think the answer is two-fold: (*i*) firstly, that compensation for accident or industrial disease must be based upon the principle of *compulsory insurance*, and (*ii*) secondly, that the insurance scheme must be a part of a national programme of social insurance, under which the carrier of insurance is either the State or, preferably, a special tripartite organisation along the lines proposed for the present scheme. I shall state my reasons for this view presently, but before doing so, it may be convenient to consider certain preliminary aspects of workmen's compensation as it stands at present.

Apart from the fact that the establishment of health insurance will necessitate overhauling of workmen's compensation, there is no doubt that the entire question of Industrial Disability needs careful reconsideration *per se*. With due respect to the Royal Commission on Labour, who in their *Report* (pp. 295 ff.) paid a tribute to the "smooth working" and success of the Workmen's Compensation Act, it may be stated that the administration and operation of the Act have been a comparative failure. This has been due not so much to any deficiency in the administrative agencies or in the provisions of the Act itself, but to the inherent defects of the method of approach itself. In the first place, the worker's illiteracy and ignorance of the law constitute a great obstacle in the way of claims being either presented or pressed. His dependants and survivors, mostly women and children, who generally live in the village far from the industrial areas, are not only ignorant but utterly helpless. They cannot be expected to go through the procedure of claiming and obtaining compensation, which is both costly and dilatory. Hundreds of claims must be going by default owing to this factor alone. Secondly, the costs of litigation are not only beyond the capacity of the worker, but also often not commensurate with the compensation obtained, while the compensation itself might be a speculative proposition. Thirdly, an injured worker runs the risk of losing his job, on top of losing a limb, if he decides to fight a case or even serve a notice on the employer, and he has often to accept a much smaller amount than is legally due to him. Fourthly, there is the difficult problem of legal aid to the claimant worker. No doubt public-spirited lawyers in some towns, trade unions and well-intentioned inspectors of factories have often taken interest in individual cases, but such cases are few and far between. In all probability, if the workers were given adequate legal aid, the extent of litigation would have been enormous. In the United Kingdom, an incredible amount of litigation takes place every year and a great deal of money is spent on legal, medical and administrative expenses. The Holman Gregory Committee reported in 1920 that "during the last five years the employers had to pay £100 in premium for every £48 paid out in benefits to the injured workman." We have no corresponding figures for India, but here probably the expenses to the employer have been kept down not by economical methods of administration or by reason of legislative perfection, but by *supression* and *default*.

Compensation is awarded to an injured workman under the Act for "personal injury caused to him by accident arising out of and in the course of employment." The legal fictions and arguments arising out of this innocent-looking phrase are so many and so confusing that the whole workmen's compensation law has become in most lands a meaningless jargon, helpful alone to the legal profession but scarcely so to the working class. In this connection, Miss Chambers in a piquant contribution on the subject in *Social Security* (Ed. Robson, pp. 60-1) remarks as follows:

"The intention of Parliament as here expressed seem to the layman fairly clear; yet the interpretation of these apparently simple words has produced volumes of court cases and, as Sir Henry Lesser points out, has proved one of the most fruitful sources of revenue to young barristers. It has also resulted in a considerable amount of hardship and injustice to the injured worker, whose economic and educational disabilities may put him at a great disadvantage when he is confronted with all the legal resources available to a large insurance company or employers' association, unless he is protected by a trade union or has other legal aid."

To arise out of employment, the accident must be sustained while the injured worker is engaged in doing something which it was his duty as part of employment to do, and the mere fact that a workman is injured while he is at work is not sufficient, even if he can show that the accident would not have taken place, if he had been elsewhere. In other words, as put by Sir A. G. Clow (*Indian Workmen's Compensation Act*, p. 47), the worker must show that "the accident has a causal and not merely fortuitous relation with his employment." The term "accident" itself has gone through revolutionary interpretations, in the course of which the lawyers have indulged in the ancient pastime of drawing distinctions without differences. The legal confusions in India, on the whole, have followed those of the British model, which it must be remembered differs materially in various respects from similar measures adopted elsewhere in the world. I am not quite sure that the British model has been either so scientific or so successful that its almost verbatim imitation in this country was justified. However, this is a subject which might take us much farther afield than my terms of reference would permit. The main fact which needs emphasis here is the futility and wastefulness of the present law. As Sir William Beveridge puts it: "Interpretation of words has been a fruitful cause of disputes in the past; whatever words are chosen, difficulties and anomalies are bound to arise. A complete solution is to be found only in a completely unified scheme for disability without demarcation by the cause of disability." (*op. cit.*, p. 38).

The Indian Act has no doubt been partially revised on the recommendation of the Royal Commission, yet in its practical operation it has been far from satisfactory. The Bihar Labour Enquiry Committee (1940) made the following comment on the working of the Act in Bihar: "While we are aware that there are employers who are giving to their employees the full benefit of the Act, our enquiries have painfully disclosed to us the fact that it is not enjoyed by the workers in many concerns. Many of the workers are not even aware of the existence of the Act and are content to accept as an act of compassion whatever may be offered to them by the employers. The Civil Surgeon of Singhbhum has given us the following figures. It may be noted, however, that it is not clear how many of these cases were entitled to compensation under the Act, although it will not be far wrong to assume that there may have been evasion of the Act in many of them. In 1937, 4 persons received compensation from a Company, the hospital records of which showed 510 injury cases and 82 deaths from all causes. In another establishment, 50 received compensation out of 8,771 injured cases and 65 deaths in the hospital, while 764 injuries and 14 deaths in one and 1,001 injuries and 29 deaths in another *resulted in no compensation at all.*" (Italics mine). These figures are astounding in themselves, but the following figures showing the comparative position in India and abroad may also be found instructive:—

TABLE 48.—*Workmen's Compensation—Comparative Figures.*

(*i*) Country	(*ii*) Year	(*iii*) Number of persons covered	(*iv*) Number of compensable accidents	(*v*) Percentage of (*iv*) to (*iii*)
*South Africa**	1933	252,960	11,266	4·4
Canadian Provinces:—				
(*a*) Alberta	1933	56,921	8,160	14·3
(*b*) Br. Columbia	1933	118,000	18,274	15·4
(*c*) Manitoba	1933	45,000	6,608	14·6
Chile	1933	156,611	21,680	13·7
*France***	1926	8,247,200	11,552,507	18·8
Luxemburg	1933	35,573	†	29·5
Italy††	1933	2,217,005	256,169	12·0
India§	1938	1,737,755	33,494	1·9
	1939	1,751,137	36,006	2·0
	1940	1,884,428	41,079	2·2

Figures have been generally collected from *International Survey of Social Services*, Vols. 1 and 2, Geneva, 1936. They were available only for the countries included in the table above. Figures for India have been collected from *Statistics of Factories* and not from *Workmen's Compensation Statistics* as these latter cover non-factory workers also.

The above figures cannot indicate that Indian factory workers are less liable to accidents, or that they are more careful than workers abroad, or that working conditions and safety provisions in factories are more up-to-date here than elsewhere, but only that a preponderant number of accidents is neither brought to light nor compensated for. It is also a significant fact that the number of compensation cases in which industrial diseases were the subject of litigation has been extremely small.

Schedule III appended to the Act, which gives a list of occupational diseases, together with the occupations which might cause them, is extremely narrow in its scope. In Britain, the original Act had only six items, but by order of the Secretary of State, the list was later extended so as to cover 37 diseases.§§ Here, however, apart from Anthrax, which is mentioned in Section 3 (2), the list included only six diseases, and although the Government of India is empowered by the Act, few additions have in fact been made. Thus, in 1937, three diseases only were added by notification, namely, arsenical poisoning or its sequelae, pathological manifestations due to radium or other radio-active substances and X-rays, and primary epitheliomatous cancer of the skin. The Royal Commission on Labour were of the opinion (*Report*, p. 307) that although employees might be placed at a disadvantage if certain diseases were omitted, "employers may be involved in litigation based on untrustworthy medical evidence, if wide additions were made to the existing Schedule before necessary investigations are made into the whole subject." Either this caveat of the Royal Commission or the absence of any demand for extension of the Schedule might have been responsible for the fact that so few additions have been made to the Schedule. But untrustworthiness of medical evidence or ignorance of the existence of the diseases does not necessarily dispose of the possibility that such diseases might be, as the Commission themselves admit, "more common than is generally realised and more varied than Schedule III of the Act would suggest." Apart from the fact that the list is narrow in its scope and does not include several

* Figures relate to Transvaal gold-mining industry only.

** Figures of number of persons employed are based on 1926 census and of number of compensable accidents relate to 1932. Only insured workers have been taken into account.

† Figure for accidents not available. Only the accident rate (*i.e.* percentage rate) is given.

†† Industrial diseases have been excluded.

§ Factory workers only.

§§ *CF.* Sir Thomas Legge, *Industrial Maladies*, Table VIII, facing p. 18.

occupational diseases peculiar, for example, to the textile and mining industries*, in practice *lead poisoning* in the printing industry is the only disease in respect of which complaints have been made with any degree of frequency of success. Finally, there is a large range of industrial diseases, such as pulmonary diseases due to dust (of which silicosis is the chief) which cannot be brought under the scope of the Act owing to the difficulty of deciding whether the disease was due to industrial or other causes. In fact, this difficulty of deciding the etiology of certain diseases which are common to industrial occupations and normal life *is inherent in the whole procedure of scheduling diseases.* Even where coverage of occupational diseases is all-inclusive, the solution has been far from satisfactory. Nor is it clear whether inclusion of more diseases would always be in the interest of the workers themselves, especially in a country like India, because this must lead to dismissal of workers who are suspected to be suffering from them. The extension of the term "accident" by legal fiction to cover industrial diseases has not been a successful device. Just as an accident in the factory is not categorically different from one in the street in its effects upon the health and well-being of the worker, so also the dividing line between industrial and non-industrial diseases is often not clear, and the entire legal structure separating some kinds of diseases from others for special compensation has resulted in a huge waste of effort and in legal evasion. So far as health insurance is concerned, this fact is, as stated earlier, likely to be disastrous in its consequences on the financial side. The conclusion, in this regard, therefore, is that even if the responsibility of compensation is rationalised by transferring it to private commercial insurance companies, industrial diseases, as a class, will continue to be ignored as before, and their burden will fal upon the health insurance funds.

Let us now revert to the question of future policy. The main grounds on which reform has been advocated by Sir William Beveridge in his *Report* (pp. 35-48) are so applicable to the Indian situation also that I can do no better than summarise them here. The grounds are : (*i*) that the present system rests in the last resort upon the threat of litigation, (*ii*) that no machinery is provided for asisting the worker in presenting his claim ; (*iii*) that no complete guarantee is afforded for the payment of compensation, *in spite of employers' liability insurance ;* (*iv*) that the system fails to secure maintenance of necessary income, and lump-sum payments are unjustifiable from the social security standpoint ; (*v*) that demarcation disputes are inevitable ; (*vi*) that the costs of administration, including those of litigation are higher than they need be or than they are likely to be under compulsory social insurance ; (*vii*) that, in the case of industrial diseases, there is the further risk that an employee showing symptom of an industrial disease may be discharged ; and (*viii*) that the present system ignores the most important purpose of all, namely, restoration of the injured employee to the greatest possible efficiency of production and capacity of earning as soon as possible. It is clear that if any reform is to be undertaken, it must meet these grounds and not perpetuate them.

The first principle to be accepted is that workmen's compensation must be taken out of the hands of employers and subjected to compulsory insurance. This will ensure realisation of the desideratum that the risks should be pooled and no individual employers, big or small, or his contractor should be suddenly exposed to bankruptcy. Also there will be a better guarantee of payment.

But the question of agency or carrier for compulsory accident insurance is of far greater significance than that of mere compulsion. In India, at present, the employer himself largely deals with the liability arising from accident under the Act. Private insurance companies have not yet been able to influence this market to any material extent, for owing to the opportunities available for evasion, the employer finds it cheaper to meet the claims himself, if at all. Once, however, insurance becomes compulsory, if private companies are allowed to operate in this field, we shall be creating new vested interests which it would be difficult to dislodge later. In the West, in spite of company insurance, litigation has been rampant. As stated earlier, in the United Kingdom, for example, employers had to pay £100 in premium for every £48 paid out in benefits to the injured workman. This great leakage has been due to both litigation and high administrative costs. Apart from litigation, there is neither guarantee nor security to the worker as regards payment of compensation. In this respect, a unified social insurance fund will always possess greater financial strength and will obviate the huge costs of litigation. What is more, it will be administratively cheaper. Again, in the case of private insurance, there is always the possibility of collusion between employer and company ; for rebates will be available for low accident experience and the next year's premia will be based upon this year's experience, which obviously it would be in the interest of the employer to suppress and minimise. Insurance companies will be better armed than workers for litigation, and workers may be persuaded to accept lump-sum agreements. This is what has actually happened elsewhere. Thus, Miss Rosalind Chambers (in Robson's *Social Security*, p. 73) remarks that "on several occasions in the experience of the present writer, insurance companies have made offers of ridiculous amounts to injured workmen ; when it became clear that the claimants had adequate legal advisers who were prepared to take up their claims, these offers were substantially increased." Thus, the necessity of providing legal aid to the worker will still be there and this necessity will be both artificial and costly. The "legal lottery" methods which are a feature of the present system involving a price for each accident will still complicate the procedure. On the other hand, a system of mutual insurance under the agency of the State, or better still, a tripartite body, such as the one proposed for health insurance in this Report, will be less costly from the administrative standpoint and will provide greater security to the worker. It will have this great advantage, moreover, that it will be able to deal with the problem of prevention of accidents and thus reducing future costs to a great extent, which private companies will not be able to do. Thus, *while private insurance fails to touch any one of the many*

* Such as Industrial Dermatitis and various forms of Cellulitis and Bursitis

objections raised by Sir William Beveridge to the existing system, compulsory social insurance is capable of rectifying all the defects. If compulsory insurance under the aegis of the State is feasible in the case of sickness, or to take a recent example, in that of war injuries, it should be equally feasible in that of industrial accident and disease.

As against the case for inclusion of workmen's compensation under a general scheme of social insurance, there are only two main arguments on the other side. The first is that liability on the employer provides an incentive for him to take due precautions against accident, while under a State system, this incentive may diminish. This argument only emphasises the need for more stringent rules and action on the part of the State in respect of safety provisions and factory conditions. One can be sure that under a State system, accident prevention will be one of the first items on the agenda. Thus, the Statutory Associations proposed by Sir William Beveridge (*Report*, paras 90-92), which are an integral part of his scheme, will have the following important functions :

(*a*) Promotion of safety in the industry, in cooperation with the department or departments responsible for safety regulations by research into the causes of accidents, by propaganda and instruction, and in other ways.

(*b*) Promotion of measures for rehabilitation and re-employment in that industry, in cooperation with the general national organs for that purpose covering all industries.

(*c*) Advice on the making of all regulations affecting safety in the industry, the scheduling of industrial disease, and methods of assessment of earnings.

(*d*) Collecting from individual employers their quotas of the total levy required in the industry as a whole, in accordance with a scheme to be prepared by the Association and approved by the Ministry of Social Security.

(*e*) Establishment of schemes to supplement the benefits statutorily secured to all injured employees.

The second argument is based upon the theory that accident and disease " at work " should be exclusively a charge on industry itself. This theory is somewhat out-of-date now, but even assuming its validity, it would still be possible, actuarially speaking, to charge the liability arising from industrial disability to industry by way of a simple addition to the employer's contribution only. In view of the fact, however, that both accident and disease are not categorically distributed between industry and normal life and there is a large twilight zone, the course suggested by Sir William Beveridge of making compensation *partly a liability of social insurance and partly one of the particular industry concerned is probably most suitable.* (Vide his *Report*, para 89).

APPENDIX XXVII.—Some Factual and Statistical Data relating to Labour Conditions in certain selected Indian States.

Baroda.

Among the large industrial establishments in the State, the textiles are the most important. The average daily number of workers employed in various industries are given below :—

Table 49.

Industry	1939-40	1940-41	1941-42	1942-43
Textiles	31,047	609	33,757	34,515
Engineering	492	568	690	758
Minerals and Metals	..	..	..	..
Other Industries	5,604	6,927	6,632	7,815
Total ..	37,143	41,104	41,079	43,088

2. Baroda has its own *Factories Act*, which follows the British Indian Act, but it has no provision limiting the weekly hours of work or giving weekly holidays, though a minimum of 4 holidays in a month is compulsory, and so also not less than 52 holidays in a year. The *Workmen's Compensation Act* of Baroda extends the British Indian enactment with modifications to suit local conditions. With modifications, again, the Bombay *Maternity Benefit Act* applies to this State ; the rate of maternity benefit however is 6 annas as against 8 annas in the Bombay Act. The Baroda *Trade Unions Act* though generally enacted on the lines of the British Indian Act omits Sections 16 and 17 regarding political funds and criminal conspiracy. The *Trade Disputes Act* has also been modelled after the British Indian enactment that there is no provision corresponding to Section 18A, regarding conciliation officers. The *Payment of Wages Act* is again a copy of the corresponding British Indian measure though certain modifications have been made to suit local requirements.

3. Labour in the State seems to be migratory in nature. The factories employ British Indian labour to a substantial extent and some of the local labour migrates to British Indian territory as well. Most of the labour appears to be permanent. *Badli* labour is not as a rule employed ; only some of the textile mills and the Baroda Antigas Co. and Burma-Shell use such labour. *Badli* workers are paid directly by the principal employer. *Badli* control systems are in force in about three factories. Employment of contract labour seems to be fairly prevalent. Night shifts are generally worked, particularly in textile mills, especially when there is a rush of work. Only textile labour seems to be organised in trade unions to a substantial extent. Wages are paid on all conceivable period-bases, though the monthly basis is evidently the most widely prevalent, while weekly and fortnightly bases also obtain practice. " Hapta "—wise payment is not unknown and a " hapta " sometimes means 12 days and sometimes 16 days. Most of the workers seem to be getting more than 8 annas a day

The Cotton Fabrics Ltd., Baroda, pay piece-wage workers for overtime on the basis of their monthly wages while there is some such arrangement in Shri Yamuna Mills Ltd., Baroda, as well. But other factories either do not work overtime or do not engage piece-rate workers. There is a Maternity Benefit Act in force in the State but its working seems to have been put into jeopardy by several factors. In several mills, no claims have yet been made in this regard. Many of the factories do not employ any female labour; this is the case with, for instance with the Petlad Turkey Red Dye Works Co. Ltd., the Alembic Chemical Works Co. Ltd., the G. B. S. Railways, the Cotton Fabrics Ltd., the Associated Cement Cos. Ltd., at Port Okha, the Baroda Anti-gas Co. Ltd., etc. Seasonal factories, in the very nature of things, never have to pay maternity benefits. The Tata Chemicals, Ltd., Mithapur, state that "maternity benefit is being paid whenever female workers report to us and comply with the rules provided under the Maternity Benefit Act. The rules, however, cannot be enforced in the present circumstances and the benefit under the Act is not therefore generally availed of."

4. In every factory, there is arrangement for first aid facilities while some of them like the Alembic Chemical Works (Baroda), the Associated Cement Company (Post Okha), and the Tata Chemicals Ltd. (Mithapur), have their own dispensaries working under qualified doctors.

Gwalior.

In Gwaliar, cotton textiles are the most important industry followed by leather industry, pottery, engineering and cement. The industrial labour force of the State amount to about 17 thousands and is distributed as follows :—

TABLE 50.—*Number of workers employed in different industries in the year* 1942.

Industry.	Total No. of workers employed	Industry	Total No. of workers employed
Government and local Fund Factories.		*All other Factories.*	
Printing Presses	189	Textiles	15,096
Railway Workshops	65	Tobacco	140
Distrillery	98*	Cement	374
Engineering	387	Match	97
Leather	591		
Water Pumping Stn.	91	Total ..	17,463
Pottery Works	435		

*Figure for 1941.

2. The State has enacted several legal measures to protect and regulate labour. There is the *Employment of Children's Labour Act*, which in general follows the British Indian Act with changes to suit local conditions. The *Pledging of Children's Labour Act* and the *Employer's Liability Act* are almost exact copies of British Indian Acts. The *Fatal Accidents Act* provides compensation to families for loss occasioned by the death of a person caused by actionable wrong. The *Workmen's Compensation Act* is also modelled after the British Indian Act. The *Maternity Benefit Act* and the *Payment of Wages Act* are awaiting H. H's assent.

3. Two of the big cotton mills in the State, engaging about 6,000 workers each, maintained their own fully equipped hospitals where free treatment is given to mill workers and their dependants.

Hyderabad.

1. Hyderabad has several engineering, textile and minerals and metals factories. The following table shows the average number of workers employed in them :—

TABLE 51.—*Average Number of Workers employed in Factories.*

Year.	Textiles (Spinning and Weaving)*				Engineering†			Minerals and Metals††		
	Adults									
	Men.	Women.	Children.	Total.	Electricity & Mint.	Engineering workshops under N.S. Rly.	Total.	Men.	Women	Total.
1348 Fasli (6-10-38 to 6-10-39)	7,583	1,694	269	9,546	1,295	2,428	3,723	822	60	882
1349 Fasli (6-10-39 to 6-10-40)	8,628	1,448	416	10,532	1,349	2,362	3,711	773	44	817
1350 Fasli (6-10-40 to 6-10-41)	9,883	1,904	371	12,158	1,212	2,563	3,775	828	53	881
1351 Fasli (6-10-41 to 6-10-42)	11,033	1,927	386	13,346	1,295	2,747	4,042	1,638	63	1,701

* All the factories belong to private individuals and firms.
** There is no "adolescent" class under the Hyderabad Factories Act.
† All factories belong to Government and Local Fund.
†† The Shahabad Cement Factory alone falls under this category.

It would appear from the above table that the Scheme, if applied to the States, would cover about 19,089 workers in the State of Hyderabad.

2. The labour working inside the State is protected and governed by five legal enactments. The first is an Act for the Regulation of Labour Contracts and deals with breach of contract on the part of artificers, workmen and labourers. The *Mines Act* provides for the regulation and inspection of mines. It includes *inter alia* safety provisions for workers but there are no provisions relating to hours of work and weekly rest. The *Hyderabad Factories Act* generally follows the corresponding British Indian Act, but the daily hours are 11 and the weekly hours are 60. The *Workmen's Compensation Act* follows, with some changes, the corresponding British Indian Act. The *Maternity Benefit Act* generally follows the Bombay Maternity Benefit Act.

3. The labour employed in the industries intended bo be covered by this Scheme bears several interesting characteristics. This labour is migratory only to a negligible extent. About 2% of the British Indian labour is employed in factories of this State, while labour migrating from this State to British India for employment is negligible. About 90% of labour in perennial factories is permanent. The System of *badli* or substitute workers is in force, but generally the company employing *badli* workers pays them. There is, however, no *badli* control system prevalent in factories, and in the textile mills the *badli* workers are entered as spare hands.

There is no contract labour in the textile mills and engineering workshops. There are night shifts in all cotton spinning and weaving mills, cement, paper, sugar, starch and ground-nut oil factories. There is a recognised Trade Union of railway workers but there is none of other workers. Wages are generally paid on a monthley basis, either in the 1st week or by the 10th of a month. The level of wages in factories ranges between Rs. 5 and Rs. 400. In the mint, permanent workers get from Rs. 12 to Rs. 250 and temporary worker s are paid from As. 8 to Rs. 4/10/- per day. In electricity concerns the range is Rs. 5 and Rs. 400.

In the Osman Shahi Mills, the minimum basic wage is As. 12 per day. In Azamjahi Mills, the wages are as follows :—

Single spinners—Rs. 18 per mensem.
Double spinners —Rs. 25 per mensem.
Single weavers—Rs. 23 per mensem.
Double weavers—Rs. 36 per mensem.

On the whole, more than 80 % of workers may be regarded as earning a basic wage of As. 8 or more per day. There is no provision under the Factory Rules for the calculation of a daily rate for overtime in the case of piece-wage workers. As mentioned above, there is a Maternity Benefit Act in force which began functioning late in 1351 Fasli (July 1942). It is stated that so far there have been no complaints regarding dismissal of any woman worker, in the early months of her pregnancy or of refusal or delay in payment of maternity benefits. In 1351 Fasli (October 1941 to October 1942) 3,937 females were covered by this Act.

4. There are 151 dispensaries and hospitals in the Dominions of which 2 are aided (the Leper Home and Hospital, Dichpally, and the Muthampally Dispensary in the Nalgonda district) and the rest are Government, comprising 22 in Hyderabad city and suburbs and 127 in the districts. Out of the city dispensaries and hospitals, the Osmania Hospital (with 749 beds) and the Victoria Zenana Hospital (with 300 beds) are special institutions. In the year 1351 Fasli (October 1941-October 1942) the daily averages of in-patients and out-patients were 2,673 and 22,527 respectively ; 3,094 beds were available for institutional treatment ; the percentage of mortality was 5·05 ; surgical operations performed were 123,788 of which 11,254 were major and 112,534 were minor, and the ratio of death percentage in surgical cases was 0·2. Besides this, there are private hospitals, nursing homes and dispensaries in the city of Hyderabad and also in the districts, which are run by Missions, private institutions and private practitioners. The important factories have their own dispensaries medical officers, nurses and midwives and creches.

Indore.

1. Indore has seven chief enactments regulating conditions of labour in the State. There is a *Factories Act* which follows generally the British Indian Act. The *Workmen's Compensation Act* also follows the corresponding *British Indian Act.* There is a *Maternity Benefit Act* as well which is modelled after the parallel measure in Bombay. The *Trade Disputes Act* (1933) provides for the reference of disputes to conciliation officers and Boards of arbitration, and also containing provisions regarding picketing and illegal meetings. The *Trade Disputes Conciliation Act* (1938) provides for the prevention and settlement of trade disputes by conciliation and for the appointment of Labour Officers to watch the interests of workers. It applies to textile trade and industry but it may be extended to other trades or industries. *The Trade Unions Act (1939)* and the *Payment of Wages Act* (1939) follow the respective British Indian Acts.

2. The Indore State, in general, is self-sufficient in regard to obtaining labour for all industries in the State. A very small percentage of labour immigrates from British India, mostly from villages in the U.P., Khandesh and Berar. Similarly, some percentage of labour also emigrates from this State to British India and the adjoining Indian States for employment in local industrial concerns. About 85% of the labour is in permanent employment in perennial factories (textile mills in general in the State) and the rest stands as *badlis* or temporary workers. *Badli* control system is already in force in all the mills and the badli workers are paid by the employers through the musters. Generally 70% of the workers are employed in the mills as time workers, and the rest as piece-rate workers. No labour is generally employed through contractors in factories working in the State. The Payment of Wages Act of the State does not allow collection of any contribution except mentioned in Section 7 of the Act, by any agency without specific sanction from the prescribed Authority under the Act. All textile mills in Indore are at present working night shifts. There are three trade unions registered under the Trade Unions Act in the State and more than 25% of the total labour is on the rolls of the Unions. Wage periods are expressly regulated by Section 5 of the Indore Payment of Wages Act, according to which no payment can be withheld after the 10th of the next month. Payment of wages is made to the workers in the day and night shifts during working hours. Advances are also paid to the workers on the same day between 22nd and 25th of the month and also on festival days if requested by the workers. More than 80% of workers earn a basic wage of not less than 8 annas per day. Generally piece-rate workers do not work over-time. The time workers, inclusive of the piece-rate workers, if working over-time, are paid for the over-time work at 1½ of their basic wages. The Indore Maternity Benefit Act is said to have been very successful in granting benefits to women workers prescribed under the Act. No case or complaint has been received by authorities where a woman worker was dismissed or discontinued from service in the early months of her pregnancy. The followig are the figures of the Maternity Benefit actually paid to the workers by mills employing women workers :—

TABLE 52.

Maternity Benefit in Indore.

Year.	No. of women who get benefit	Amount (Rs.)
1937-38	4	51
1938-39	266	3,803
1939-40	212	4,616
1940-41	295	4,631
1941-42	372	6,801

A. The following figures show the average number of workers employed per day in the local textile mills in recent years :—

TABLE 53.

Number of workers employed in Textile Mills in Indore.

Year.	Males	Females	Children	Total
1937-38	20,266	2,279	1,101	23,646
1938-39	18,479	2,126	676	21,281
1939-40	16.892	2,507	466	19,865
1940-41	19,101	2,534	440	22,075
1941-42	21,959	2,511	923	25,393

3. Free hospitals have been opened by the State for the benefit of all the subjects at different places of which the mill and factory labour also takes advantage. In some mills, hospitals on a smaller scale are run free of charge, and in others dispensaries are run for the supply of free medicines to the labourers. A maternity home is also provided and run by one of the mills where treatment is given to the female workers of Indore free of charge

Mysore.

1. In Mysore, which is a highly industrialised state, according to the *Return of Large Industrial Establishments in the Mysore State for the Calendar Year 1941*, there are 417 large Industrial Establishments out of which 381 are perennial and 36 seasonal. They employ on the average a total of 80,455 persons ; 75,778 in perennial and 4,677 in seasonal factories. Besides there is a large number of other industrial establishments (about 150 according to the estimate of the Labour Commissioner in Mysore) in which less than 10 persons are employed daily. Thus the total number of industrial establishments in Mysore is about 600 and the total labour force in the State about 84,000.

However, the number of factories in Mysore subject to the Mysore Factories Act 1936, which conforms to the corresponding British Indian Act in all particulars is 350. Out of these, 299 are perennial and 51 seasonal. As regards ownership, 32 are owned by Government, 39 by private companies and 279 by private parties. The number of workers employed in these industrial undertakings subject to the Factories Act is 38,694 of whom 32,899 are male adults, 4,432 women and 1,363 children.

The following table gives the number of factories and number of workers engaged therein for the years 1940 and 1941, according to the class of industry :—

TABLE 54.

Industries	(1940) Number	(1940) Persons	(1941) Numbers	(1941) Persons
1 Textiles	144	22,159	113	23,932
2 Engineering	27	3,544	24	8,017
3 Minerals and Metals	20	28,542	23	28,086
4 Others	313	19,676	257	20,420
Total ..	513	73,921	417	80,455

It would appear from this table that if the Scheme is applied to the Textiles, Engineering and Minerals and Metal industries it will cover about 60,000 workers ; and if it is applied to all the industries it will cover about 80,000 workers.

Travancore.

The average daily number of workers in large industrial establishments in the State during various years are given below :—

TABLE 55.

Industry	1939	1940	1941	1942
Government Factories	416	586	787	935
Textiles	817	828	1,179	1,433
Engineering	1,080	1,186	1,372	1,530
Minerals and Metals	4,203	5,379	2,933	1,788
Total ..	6,516	7,979	6,271	5,686

In 1942 out of the total of 5,686 workers 5,052 were adults and 634 adolescents. There are no children employed in large industrial establishments in the State.

1. The State has enacted a *Trade Unions Act* which follows the British Indian Act of 1926 except that the State has omitted Section 17 of the Act regarding "Criminal Conspiracy in trade disputes". The proportion of outsiders to be admitted as office-bearers is one-fourth of the total number of officers as against one-half in the British Indian Act. The *Travancore Trade Disputes Act* almost exactly follows the corresponding British Indian Act but there is no provision regarding Conciliation Officers The *Factories Act* of Travancore, again, follows the British Indian Act, but Sections 45 and 54 of the former prohibit the employment of women and children except between 7 a.m. and 5 p.m. as against the hours between 6 a.m. and 7 p.m laid down in the later Act. The *Workmen's Compensation Act* of the State also follows the British Indian model while the *Payment of Wages Act* of the State has been applied to factories and mines only.

2. Contract labour is generally employed in the tea and rubber factories in the plantations. The approximate number of such factories is 100. The approximate number of workers thus employed on a day in 1942 was about 4,000. Night shifts are worked in the following industries :—(a) extraction of cocoanut oil, (b) paper, (c) distillery, (d) tiles and bricks, (e) sugar, (f) wood work, (g) engineering work, (h) Cashew oil extraction, (i) textile, (j) rubber goods manufacture, and (k) aluminium works. There are no less than 34 trade unions in the State. These Unions mostly relate to workers in coir and cotton textiles, engineering works and in other factories such as paper, sugar and oil mills. Labour in plantation factories does not seem to have been organized in trade unions so far. The wage periods are either a week or a forthnight. There is provision under the Travancore Factories Act for calculating over-time wages. This is similar to the corresponding provision in the British Indian Factories Act. The wages in factories usually range between 6 and 12 annas per day. The Travancore Maternity Benefit Act recently passed has not yet come into force.

3. There are Government dispensaries and hospitals in most of the towns in the State. In the estates and in a few factories, there are private free dispensaries owned by the respective companies First-aid requirements are provided in all factories.

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